

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8225

1 PLACE OF DEATH

County Washington (391)

Village or City Hagerstown (No. Bellview) St. — Ward —

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 302

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME William Aaron

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
3 SEX <u>male</u>	4 COLOR OR RACE <u>colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widower</u>	16 DATE OF DEATH <u>Aug 4</u> , 191 <u>4</u> (Month) (Day) (Year)	
6 DATE OF BIRTH <u>march 31</u> , 18 <u>56</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY that I attended deceased from <u>July 15</u> , 191 <u>4</u> , to <u>Aug 4</u> , 191 <u>4</u> , that I last saw him alive on <u>July 31</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>6 P.</u> m.	
7 AGE <u>58</u> yrs. <u>4</u> mos. <u>4</u> ds. OR <u>—</u> min. ?			The CAUSE OF DEATH* was as follows: <u>Carcinoma of lower jaw & mouth</u>	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>laborer</u> (b) General nature of industry, business, or establishment in which employed (or employer)			(Duration) <u>1</u> yrs. <u>—</u> mos. <u>—</u> ds.	
9 BIRTHPLACE (State or country) <u>Virginia</u>			Contributory <u>Starvation & exhaustion</u> Secondary	
PARENTS	10 NAME OF FATHER <u>Samuel Aaron</u>		(Duration) <u>—</u> yrs. <u>—</u> mos. <u>4</u> ds.	
	11 BIRTHPLACE OF FATHER (State or country) <u>Virginia</u>		(Signed) <u>F. M. Hoffner</u> , M. D.	
	12 MAIDEN NAME OF MOTHER <u>unknown</u>		<u>Aug 6</u> , 191 <u>4</u> (Address) <u>Hagerstown Md</u>	
	13 BIRTHPLACE OF MOTHER (State or country) <u>unknown</u>		*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Margie Aaron</u> (Address) <u>Hagerstown, Md</u>			18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. In the State <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. Where was disease contracted, if not at place of death? Former or usual residence	
15 Filed <u>Aug 6</u> , 191 <u>4</u> <u>H. Henry Davis</u> REGISTRAR			19 PLACE OF BURIAL OR REMOVAL <u>Half way, Maryland</u>	
			DATE OF BURIAL <u>Aug 6</u> , 191 <u>4</u>	
			20 UNDERTAKER <u>A. E. Coffman</u>	
			ADDRESS <u>Hagerstown Md.</u>	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

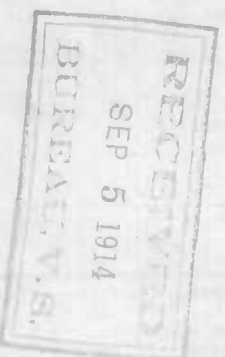
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurren) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Scarle" etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH WASHINGTON 8226
 County WASHINGTON
 Village or City HAGERSTOWN (No. FIRST NATIONAL BK BLDG.; 1 Ward)
 STATE OF MARYLAND
 CERTIFICATE OF DEATH
 Registration Dist. No. 302
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME CHARLES H. ALVEY

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE WHITE 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED MARRIED.
 (Write the word)
 6 DATE OF BIRTH APRIL 28, 1875.
 (Month) (Day) (Year)
 7 AGE 39 yrs. 3 mos. 28 ds. OR 1 day. 1 hrs. 1 min. ?
 If LESS than 1 day. hrs. min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work LAWYER
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) MARYLAND.

10 NAME OF FATHER RICHARD H. ALVEY

11 BIRTHPLACE OF FATHER (State or country) MARYLAND.

12 MAIDEN NAME OF MOTHER MARY HAYS.

13 BIRTHPLACE OF MOTHER (State or country) MARYLAND.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) MRS. R. H. ALVEY

(Address) S. PROSPECT STREET.

15 Filed 8/28, 1914 Henry Davis,
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 26, 1914.
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug. 26, 1914, to Aug. 26, 1914.
 that I last saw him alive on Aug. 23, 1914

and that death occurred on the date stated above, at 2p. m.
 The CAUSE OF DEATH* was as follows:

Self Inflicted Gun-shot Wound
in chest

(Duration) Sudden yrs. 0 mos. 0 ds.

Contributory Shock
 Secondary

(Signed) Wm. A. Suman, M. D.
Aug. 27, 1914 (Address) Hagerstown, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

ROSE HILL CEMETERY

AUG., 1914.

20 UNDERTAKER

ADDRESS

C. M. SUTER & SON

HAGERSTOWN MD.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

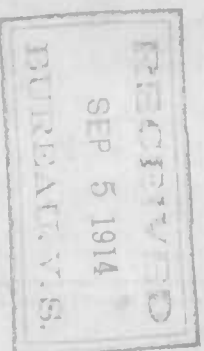
Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Saleman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 8227 Washington County Hagerstown (No. 6 Washington St. 3rd Ward) Registration Dist. No. 302

2 FULL NAME Thomas W Ankers

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH Aug 10, 1914 (Month) (Day) (Year)

7 AGE 6 1/2 hours If LESS than 1 day, hrs. yrs. mos. ds. OR min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Md

10 NAME OF FATHER Gerald T Ankers

11 BIRTHPLACE OF FATHER (State or country) England

12 MAIDEN NAME OF MOTHER Lillian Frabee

13 BIRTHPLACE OF MOTHER (State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Gerald T. Ankers

(Address) 40 E. Wash St.

15 Filed 8-11, 1914 Henry Davis REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 10, 1914 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 10, 1914, to Aug 10, 1914, that I last saw him alive on Aug 10, 1914,

and that death occurred on the date stated above, at 5:30 P. m. The CAUSE OF DEATH* was as follows:

Patient Foreman stroke (Duration) yrs. mos. ds.

Contributory (Secondary)

(Signed) A. R. Scheuer, M. D. (Address) Hagerstown, 1914

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Rose Hill Ceme DATE OF BURIAL Aug 11, 1914

20 UNDERTAKER Kraiss Bros ADDRESS Hagerstown

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

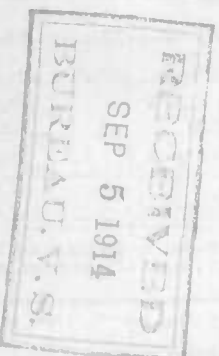
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8228

1 PLACE OF DEATH
County Washington
Village or City Near Dover

Village or City Near N - W (No.)

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED *Married*
(Write the word)

DATE OF BIRTH Sept 22, 1936
(Month) (Day) (Year)

AGE 77 yrs 10 mos 18 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE
(State or country) Va

10 NAME OF FATHER *Fielding Robert*

11 BIRTHPLACE
OF FATHER
(State or country)

12 MAIDEN NAME OF MOTHER *Mrs. M. J. ...*

**13 BIRTHPLACE
OF MOTHER**
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. F. J. Strehus

(Address)..... Kuyker, H. H.

16 Filed Aug 13, 1914 V. M. Reichard Social REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 311

St.:.....Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Aug 10, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from
Saw the deceased
that I last saw her alive on her death

and that death occurred on the date stated above, at.....m

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

Contributory Secondary

(Duration) yrs. mos. ds.
(Signed) W. M. Reschard, M. D.
Aug 13, 1914 (Address) Fair Play

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,
OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
If not at place of death?.....

Former or usual residence

1. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
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Shepherdstown, W. Va Aug 13, 1914

20 UNDERTAKER	ADDRESS
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M. C. Richard Hair Play.

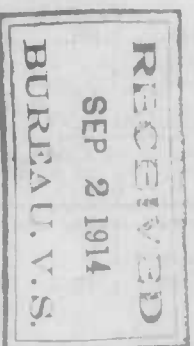
REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-theia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 8229 ✓ S.
County Washington

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 302

Village or City Hygesstown (No. 22 1/2 St. 3 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME unmarried child Barr

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH Aug 7, 1914
(Month) (Day) (Year)

7 AGE _____ yrs. _____ mos. _____ ds. It LESS than 1 day, _____ hrs. _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work. _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER William Barr

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Maud A Munson

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Barr

(Address) Hygesstown Md

15 Filed 8/7, 1914 Henry Davis

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 7, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____.

that I last saw him alive on _____, 191____.

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

(Still born)

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) M. Munson, M. D.
Aug 7, 1914 (Address) Hygesstown

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Shensville Md Aug 7, 1914

20 UNDERTAKER ADDRESS

H. C. C. C. Hygesstown Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

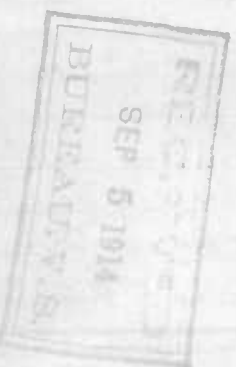
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 20 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con- genital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County

wash

8230

Village or City

Highfield Mr

(No.)

St.; Ward)

2 FULL NAME

Georgie Willis Bell

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

313

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

married

6 DATE OF BIRTH

June 25th, 1859

(Month)

(Day)

(Year)

7 AGE

55⁺

yrs.

1

mos.

21

ds.

It LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

none

9 BIRTHPLACE

(State or country)

Prince George Co., Va.

10 NAME OF FATHER

Dr. John Willis Gurley

11 BIRTHPLACE OF FATHER

(State or country)

Southampton Co.

12 MAIDEN NAME OF MOTHER

Anna E. Little

13 BIRTHPLACE OF MOTHER

(State or country)

Southampton Co., Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. A. G. Carroll

(Address)

Cascade, Md.

15

Filed

191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug

14

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

May 19

1914

to Aug 14

1914

that I last saw her alive on

Aug 8

1914

and that death occurred on the date stated above, at

10 p.m.

THE CAUSE OF DEATH* was as follows:

Pulmonary hemorrhage

(Duration)

yrs.

mos.

4 ds.

Contributory Secondary

Pulmonary tuberculosis

(Duration)

yrs.

6 mos.

ds.

(Signed)

Florence G. Stoll

M. D.

8/15

1914 (Address) Bluffs Ridge, Summers Va.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs. mos. ds.

In the

State

yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Unknown

Unknown, 191

20 UNDERTAKER

ADDRESS

Goon

W. Asperman

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH
County Washington 8231

Village or City Hippies (No. _____)

2 FULL NAME

Levin Blanchard

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 313

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Unknown, 1 (Month) (Day) (Year)

7 AGE 21 yrs. 2 mos. 2 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Unknown (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Unknown

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant F. E. Grove
(Address) Wynneboro, Pa

15 Filed _____, 191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 20, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from August 18, 1914, to Aug. 20th, 1914, that I last saw him alive on Aug. 20th, 1914

and that death occurred on the date stated above, at 5:15 pm

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) Several yrs. mos. ds.

Contributory (Secondary) None (Duration) _____ yrs. mos. ds.

(Signed) R. F. Hussy, M. D.
Aug. 20th, 1914 (Address) Hippies Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. 3 mos. _____ ds. In the Unknown State _____ yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence Baltimore, Md

19 PLACE OF BURIAL OR REMOVAL Baltimore, Md DATE OF BURIAL _____, 191

20 UNDERTAKER F. E. Grove ADDRESS Wynneboro, Pa

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County WashingtonVillage or City Dorrowsville (No. _____)

St. _____ Ward _____

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 311

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME John William Boppe

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Child

6 DATE OF BIRTH

April 26, 1914
(Month) (Day) (Year)

7 AGE

3 yrs. 19 mos. 19 ds. OR 1 day, 1 hrs. 1 min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

Child

9 BIRTHPLACE (State or country)

Maryland

PARENTS

10 NAME OF FATHER

Martin Luther Boppe

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Amelia Jacobs

13 BIRTHPLACE OF MOTHER (State or country)

Great Brunswick

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

M. Luther Boppe

(Address)

Williamspart

15

Filed

Aug 16, 1914 V.M. Reichard
Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

August 15, 1914
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from August 15, 1914, to August 15, 1914, that I last saw him alive on August 15, 1914.and that death occurred on the date stated above, at 3 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Cerebral MeningitisChronic Brain Fever
since birth (Duration) 3 mos. 19 ds.Contributory
Secondary(Signed) D. T. Leshier, M. D.
August 16, 1914 (Address) Williamspart Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Williamspart Md Aug 17, 1914

20 UNDERTAKER

ADDRESS

James W. Kups Williamspart Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

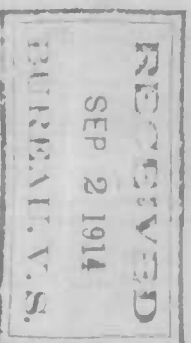
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer" "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

8233

County

Washington

Village or City

Hagerstown

(No.)

West Side Ave

Registration Dist. No.

302

St.; 1st

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

unnamed child of Charles B. Bostetter

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

single

6 DATE OF BIRTH

Aug. 15, 1914

(Month)

(Day)

(Year)

7 AGE

yrs. mos. ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

Charles B. Bostetter

PARENTS

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Mary E. Foltz

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charles B. Bostetter

(Address)

Hagerstown, P. D. 1, Md.

15

Filed

8/15, 1914

H. H. Davis

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

August 15, 1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw him alive on 191

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Dead in utero
Born Aug 15th 7 pm
Still Born (Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

E. H. Waples, M. D.

Aug 15, 1914

(Address) Hagerstown

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs. mos. ds.

In the

State

yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Broadfording, Md.

August 16, 1914

20 UNDERTAKER

ADDRESS

Chas. Bostetter (Jr.) Hagerstown

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

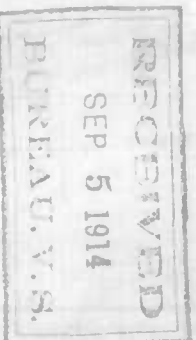
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential"), "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as probably as such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH <u>8234</u>		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Washington</u>		Registration Dist. No. <u>302</u>	
Village or City <u>Hagerstown</u> (No. <u>11</u>)		St.; Ward) <u>Bell View</u>	
2 FULL NAME <u>Elizabeth Bowers</u>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Widow</u> (Write the word)	
6 DATE OF BIRTH <u>Dont know</u> (Month) (Day) (Year)			
7 AGE <u>84</u> yrs. <u>0</u> mos. <u>0</u> ds. If LESS than 1 day, <u>0</u> hrs. <u>0</u> min. ?			
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Housework</u> (b) General nature of industry, business, or establishment in which employed (or employer)			
9 BIRTHPLACE (State or country) <u>Maryland</u>			
PARENTS	10 NAME OF FATHER <u>Bauman</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Md</u>		
	12 MAIDEN NAME OF MOTHER <u>Unknown</u>		
13 BIRTHPLACE OF MOTHER (State or country) <u>Unknown</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>J. E. Frantz</u> (Address) <u>Clearspring</u>			
15 Filed <u>8-14</u> , 191 <u>4</u> <u>Henry Davis</u> REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>Aug 13</u> , 191 <u>4</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from <u>April 1</u> , 191 <u>4</u> , to <u>Aug 13</u> , 191 <u>4</u> .			
that I last saw her alive on <u>Aug 10</u> , 191 <u>4</u> .			
and that death occurred on the date stated above, at <u>3 P</u> m.			
The CAUSE OF DEATH* was as follows: <u>Shock from a fall</u>			
(Duration) <u>—</u> yrs. <u>—</u> mos. <u>7</u> ds.			
Contributory <u>age</u>			
(Duration) <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds.			
(Signed) <u>F. N. Hoffmann</u> , M. D. <u>Aug 14</u> , 191 <u>4</u> (Address) <u>Hagerstown Md.</u>			
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. In the State <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. Where was disease contracted, If not at place of death? Former or usual residence <u>—</u>			
19 PLACE OF BURIAL OR REMOVAL <u>St Pauls Md.</u>		DATE OF BURIAL <u>8-15</u> , 191 <u>4</u>	
20 UNDERTAKER <u>Frantz Bros</u>		ADDRESS <u>Clearspring Md</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report more symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 8235
 County Washington (151)
 Village or City Hagerstown (No. 151) St.; 5 Ward
 2 FULL NAME Benjamin Franklin Burns

STATE OF MARYLAND
 CERTIFICATE OF DEATH
 Registration Dist. No. 302

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>male</u>	4 COLOR OR RACE <u>colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>
6 DATE OF BIRTH <u>July 2, 1914</u>		
7 AGE <u>1</u> yrs. <u>13</u> mos. <u>13</u> ds.		It LESS than 1 day, hrs. OR min. ?
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Infant</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>L</u>		
9 BIRTHPLACE (State or country) <u>Maryland</u>		
PARENTS	10 NAME OF FATHER <u>John Burns</u>	
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>	
	12 MAIDEN NAME OF MOTHER <u>Clara Henderson</u>	
	13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>	

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Burns
 (Address) Hagerstown, Md

15 Filed 8/16, 1914 Henry Davis
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 15, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 14, 1914, to Aug 15, 1914.
 that I last saw him alive on Aug. 15, 1914,
 and that death occurred on the date stated above, at 3:30 m.
 The CAUSE OF DEATH* was as follows:
Internal hemorrhage
due to improper diet

(Duration) yrs. mos. 1 ds.
 Contributory Improper feeding
 Secondary (Duration) yrs. mos. 20 ds.
 (Signed) Allen B. Wilson, M. D.
 , 191 (Address) Hagerstown, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
 If not at place of death?

Former or
 usual residence.

19 PLACE OF BURIAL OR REMOVAL Hagerstown, Md DATE OF BURIAL Aug 16, 1914

20 UNDERTAKER A. H. Coffman ADDRESS Hagerstown, Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

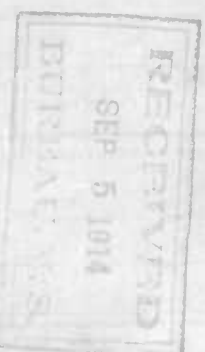
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH 8236

County Washington

Village or City Hagerstown (No. Wash. Ave St; 1st Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registered No. 302

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Sarah E. Barshick

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED widow (Write the word)

6 DATE OF BIRTH Oct 6, 1936
(Month) (Day) (Year)

7 AGE 77 yrs 10 mos 4 ds. 17 LESS than 1 day, hrs. OR min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work None (b) General nature of industry, business, or establishment in which employed (or employer) None

9 BIRTHPLACE (State or country) Ind

10 NAME OF FATHER Barton Garrett

11 BIRTHPLACE OF FATHER (State or country) Ind

12 MAIDEN NAME OF MOTHER Mary Fillpot

13 BIRTHPLACE OF MOTHER (State or country) Ma

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robert S. Barshick

823 Wash Ave Hagerstown Md (Address)

15 Filed 8/12, 194 Henry Davis REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 10, 194
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug. 3, 194, to Aug. 8, 194, that I last saw her alive on Aug. 8, 194

and that death occurred on the date stated above, at 11-30 m. The CAUSE OF DEATH* was as follows:

General Paralysis

(Duration) 7 yrs. 5 mos. 3 ds.

Contributory (Secondary) Fracture Hip

(Duration) 10 yrs. 10 mos. 10 ds.

(Signed) H. K. Davis, M. D., 8/12, 194 (Address) Hagerstown Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 7 yrs. 10 mos. 10 ds. In the State 7 yrs. 10 mos. 10 ds.

Where was disease contracted, If not at place of death? Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Petersville Md DATE OF BURIAL Aug 12, 194

20 UNDERTAKER S. Kellie Gorman ADDRESS Hagerstown Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of ----- (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 8237		STATE OF MARYLAND	
County <u>Washington</u>		CERTIFICATE OF DEATH	
Village or City <u>near Hagerstown</u> No. _____		Registration Dist. No. <u>302</u>	
2 FULL NAME <u>Mrs Louisa A. Carty.</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>widow</u> (Write the word)	
6 DATE OF BIRTH <u>Oct 23, 1834</u> (Month) (Day) (Year)			
7 AGE <u>79</u> yrs. <u>9</u> mos. <u>16</u> ds.		If LESS than 1 day, hrs. OR min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>"</u>			
9 BIRTHPLACE (State or country) <u>Maryland.</u>			
PARENTS	10 NAME OF FATHER <u>John Beard.</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland.</u>		
	12 MAIDEN NAME OF MOTHER <u>Catherine Eyler</u>		
	13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland.</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. S. M. Keudle.</u> (Address) <u>near Hagerstown, Md.</u>			
15 Filed <u>8/10-</u> , 191 <u>4</u> <u>Henry Davis</u> REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>8-9th</u> , 191 <u>4</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from <u>Aug 1</u> , 191 <u>4</u> , to <u>Aug 9</u> , 191 <u>4</u> , that I last saw her alive on <u>Aug 7</u> , 191 <u>4</u> .			
and that death occurred on the date stated above, at <u>5.15 a.m.</u>			
The CAUSE OF DEATH* was as follows: <u>Cancer of Intestines</u> <u>Sigmoid & Rectum</u> (Duration) <u>1</u> yrs. mos. ds. Contributory <u>Dysentery.</u> Secondary (Duration) yrs. mos. <u>2</u> ds. (Signed) <u>D. C. R. Muller</u> , M. D. <u>810"</u> , 191 <u>4</u> (Address) <u>State Line</u>			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OF HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence.			
19 PLACE OF BURIAL OR REMOVAL <u>Zion Ch. Yard</u>		DATE OF BURIAL <u>8/10</u> , 191 <u>4</u> .	
20 UNDERTAKER <u>Emmeline & Son</u>		ADDRESS <u>Hagerstown Md.</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

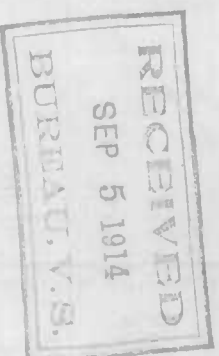
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Saleman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 8238
County Washington
Village or City Bonoboro (No. _____ St. _____ Ward _____)

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 305

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Anne Rebecca Chambers

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>
6 DATE OF BIRTH <u>Nov 18</u> , 18 <u>81</u> (Month) (Day) (Year)		
7 AGE <u>81</u> yrs. <u>8</u> mos. <u>18</u> ds.		If LESS than 1 day, _____ hrs. OR _____ min. ?
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>House-keeper</u> (b) General nature of industry, business, or establishment in which employed (or employer)		
9 BIRTHPLACE (State or country) <u>Maryland</u>		
PARENTS	10 NAME OF FATHER <u>James H. Chambers</u>	
	11 BIRTHPLACE OF FATHER (State or country) <u>Pennsylvania</u>	
	12 MAIDEN NAME OF MOTHER <u>Mary Hahn</u>	
	13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>	

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles Stinesinger

(Address) Bonoboro - Pa.

15 Filed Aug 8, 1914 Geo. M. Storr, J. P.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 6, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 1st, 1914 to Aug 6, 1914, that I last saw her alive on Aug 5, 1914

and that death occurred on the date stated above, at 12.15 P.M.

The CAUSE OF DEATH* was as follows:

General Debility

(Duration) _____ yrs. 3 mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. Hubert Wade, M. D.
Aug 8, 1914 (Address) Bonoboro, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RESIDENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bonoboro Cemetery

Aug. 9th, 1914

20 UNDERTAKER

ADDRESS

Wm. F. Best

Bonoboro, Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

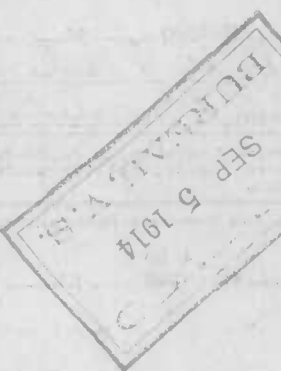
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., if..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestive," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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PLACE OF DEATH 8239
County Washington

Village or City Big Spring (No. 180)

FULL NAME Clarence L. Courtney

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 314

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE, MARRIED, WIDOWED, OR DIVORCED single
(Write the word)

DATE OF BIRTH Aug 20, 1893
(Month) (Day) (Year)

AGE 20 yrs. 11 mos. 18 ds. If LESS than 1 day, hrs. OR min. ?

OCCUPATION
(a) Trade, profession, or particular kind of work farm laborer
(b) General nature of industry, business, or establishment in which employed (or employer) helper

BIRTHPLACE (State or country) Wash. Co., Md.

NAME OF FATHER Peter Courtney

BIRTHPLACE OF FATHER (State or country) W. Va.

MAIDEN NAME OF MOTHER Luey Hull

BIRTHPLACE OF MOTHER (State or country) Wash. Co., Md.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant Lawrence Hull

(Address) Big Spring Md.

Filed August 10, 1914 H. B. Hull

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 8, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____,

that I last saw him alive on _____, 191____,

and that death occurred on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Accidental
Struck by lightning
(Duration) yrs. mos. ds.

Contributory (Secondary)

(Signature) David S. Miller, M.D.
Aug 8, 1914 (Address) Clear Spring Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL St Pauls DATE OF BURIAL Aug 10th, 1914

UNDERTAKER Frank Bros & Co ADDRESS Clear Spring

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*, *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 8240
 County Washington
 near Breathedsville (No. 9)
 Village or City Breathedsville St.; Ward
2 FULL NAME Still born child of John & Margaret Crawford
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS
3 SEX Female
4 COLOR OR RACE white
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
 (Write the word)

6 DATE OF BIRTH Aug. 10th, 1914
 (Month) (Day) (Year)

7 AGE _____ yrs. _____ mos. _____ ds. **OR** _____ min. ?
 If LESS than 1 day, _____ hrs.

8 OCCUPATION
 (a) Trade, profession, or particular kind of work _____
 (b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Maryland

PARENTS
10 NAME OF FATHER John D. Crawford
11 BIRTHPLACE OF FATHER (State or country) Maryland
12 MAIDEN NAME OF MOTHER Margaret Staley
13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Mrs. Mary Nicodemus
 (Address) Breathedsville, Md.

15 Filed Aug 10, 1914 V. M. Reichard
 Local REGISTRAR

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 311

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 8 - 10, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 8/10, 1914, to 8/10, 1914.

that I last saw h. 8/10 alive on 8/10, 1914.

and that death occurred on the date stated above, at 5 p.m.

The CAUSE OF DEATH* was as follows:
Difficult Labor

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory ☒
 Secondary _____

(Signed) John Shullen Jr., M. D.
8/10, 1914. (Address) Hagerstown, Md.

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18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Rose Hill Cemetery **DATE OF BURIAL** Aug 10, 1914

20 UNDERTAKER C. M. Suter & Son **ADDRESS** Hagerstown, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

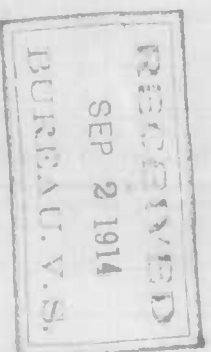
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Saleman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Coma," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septiciæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Washington

Village or ~~City~~ Mar. St. James (No. _____ St.; _____ Ward)

2 FULL NAME Nancy E. Reibert

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH Jan. 21, 1868
(Month) (Day) (Year)

7 AGE 46 yrs. 6 mos. 10 ds. If LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Isaac Rowland

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ellen Morgan

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Benjamin F. Deibert

(Address) College of St. James

15 Filed Aug. 10, 1914 C. E. Rickard
LOCAL REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 301

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug. 9, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1914 to July 29, 1914

that I last saw him Ex. alive on July 29, 1914

and that death occurred on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure
(Found dead in bed)

(Duration) Instant yrs. ____ mos. ____ ds.

Contributory
Secondary _____

(Signed) B. M. Dugan, M. D.

Aug 9, 1914 (Address) 1000 1st St. N. W.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Manor Cemetery DATE OF BURIAL Aug. 11, 1914

20 UNDERTAKER C. E. Rickard ADDRESS Fairplay, Ind.

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary, 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Ivanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH		8242	STATE OF MARYLAND	
County		Washington	CERTIFICATE OF DEATH	
Village or City		Half Way	Registration Dist. No.	301
2 FULL NAME		Walker S. De Lauder		
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)	16 DATE OF DEATH	
Male	White	Married	August - 6, 1914	
6 DATE OF BIRTH				
Oct. 16, 1876				
(Month) (Day) (Year)				
7 AGE	8 OCCUPATION		17 I HEREBY CERTIFY, That I attended deceased from	
37 yrs. 9 mos. 20 ds.	Farmer		Dec. 1913, to Aug. 6, 1914	
It LESS than 1 day, hrs. OR min. ?		that I last saw him alive on		Aug. 2, 1914
		and that death occurred on the date stated above, at		10 A. m.
		The CAUSE OF DEATH* was as follows:		Pulmonary Tuberculosis
		Contributory		Exhaustion
		Secondary		
		(Duration) 2 yrs. mos. ds.		
		(Signed) Irvin M. Hertz, M. D.		
		Aug. 6, 1914 (Address) Argersheim, Md.		
		*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.		
		18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)		
		At place of death yrs. mos. ds. In the State yrs. mos. ds.		
		Where was disease contracted, If not at place of death?		
		Former or usual residence		
		19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL	
		Sharpsburg Md.	Aug. 9, 1914	
		20 UNDERTAKER	ADDRESS	
		Dr. C. E. Rickard	Fairplay Md.	
		Local REGISTRAR		
		If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.		

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Recoiler wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 8243
County Washington

Village or City Hagerstown (No. 421, Melloullan St., 5 Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registered No. 302

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Ester Young Slists

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH April 18, 1914
(Month) (Day) (Year)

7 AGE 4 yrs. — mos. — ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) —

9 BIRTHPLACE (State or country) Hagerstown Ind

10 NAME OF FATHER Frank B. Slists

11 BIRTHPLACE OF FATHER (State or country) York Pa

12 MAIDEN NAME OF MOTHER Emma C Young

13 BIRTHPLACE OF MOTHER (State or country) York Pa

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank B. Slists

421 Melloullan Hagerstown Ind
(Address)

15 Filed 8/19 - 1914 Henry Davis
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 17, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug. 16, 1914, to Aug. 17, 1914,

that I last saw her alive on Aug. 17, 1914,

and that death occurred on the date stated above, at 4:50 P. m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum.

(Duration) yrs. mos. 2 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Johnston, M. D.
Aug. 18, 1914 (Address) Hagerstown Ind

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Ind DATE OF BURIAL Aug 18, 1914
Ross Hill Hagerstown

20 UNDERTAKER Skeller Luman Hagerstown Ind
ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

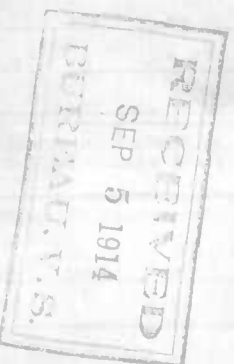
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

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1 PLACE OF DEATH 8244 *S. V*
County WASHINGTON
Village or City HAGERSTOWN (No. 215 SUMMER St.; 2nd Ward)
Registration Dist. No. 302

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME UNNAMED CHILD OF EMANUEL & STELLA DIFFENDERFER

PERSONAL AND STATISTICAL PARTICULARS

3 SEX FEMALE
4 COLOR OR RACE WHITE
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the **SINGLE**)
6 DATE OF BIRTH AUG. 20th, 1914
 (Month) (Day) (Year)

7 AGE STILL BORN
 If LESS than 1 day, hrs. yrs. mos. ds. OR min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work. NONE
 (b) General nature of industry, business, or establishment in which employed (or employer) NONE

9 BIRTHPLACE (State or country) MARYLAND.

PARENTS
10 NAME OF FATHER EMANUEL O. DIFFENDERFER
11 BIRTHPLACE OF FATHER (State or country) MARYLAND.
12 MAIDEN NAME OF MOTHER STELLA SHOPLEY
13 BIRTHPLACE OF MOTHER (State or country) MARYLAND.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. O. DIFFENDERFER

(Address) # 215 SUMMER STREET

15 8/21, 1914 *Hennig Davis*
 Filed REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 21, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 8/20, 1914, to 8/20, 1914
 that I last saw him *dead* 8/20, 1914
 and that death occurred on the date stated above, at *still born* m.

The CAUSE OF DEATH* was as follows:

Premature

Contributory
 Secondary

(Duration) yrs. mos. ds.
 (Signed) *H. E. North*, M. D.
 8/21, 1914 (Address) *Hagerstown*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OF HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
 Where was disease contracted, If not at place of death?
 Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL AUG. 21st, 1914

ROSE HILL CEMETERY

20 UNDERTAKER

ADDRESS

C. M. SUTER & SON

HAGERSTOWN MD.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

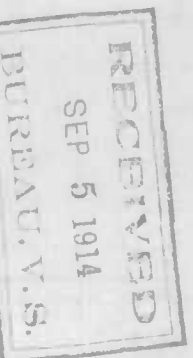
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or misarrriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 8245

County WashingtonSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 302Village or City Hagerstown (No. 30, Chapetalle St.; 2 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME unnamed Child Dixon

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH Aug 11, 1914
(Month) (Day) (Year)

7 AGE 1 day If LESS than 1 day, hrs. 1 mos. 0 ds. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9 BIRTHPLACE (State or country) Maryland

PARENTS
10 NAME OF FATHER George A Dixon
11 BIRTHPLACE OF FATHER (State or country) Pennsylvania
12 MAIDEN NAME OF MOTHER Mary Long
13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George A Dixon(Address) Hagerstown, Md

15 Filed 8-13-14 Henry Davis
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 12, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 12, 1914 to Aug 12, 1914

that I last saw him alive on Aug 14, 1914

and that death occurred on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) — yrs. — mos. — ds.

Contributory
Secondary

(Duration) — yrs. — mos. — ds.

(Signed) George A Dixon, M. D.
8/13, 1914 (Address) Hagerstown, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, If not at place of death?

Former or usual residence —

19 PLACE OF BURIAL OR REMOVAL Hagerstown, Md DATE OF BURIAL 8-13-14

20 UNDERTAKER A. R. Coffman ADDRESS Hagerstown, Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

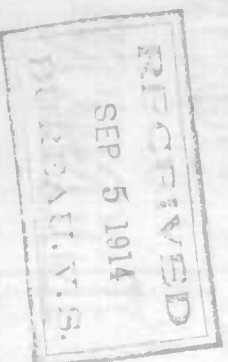
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not faithfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report more symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 8246

County

Washington

(No. 35)

Elizabeth

Registration Dist. No.

302

Village or City

Regentown

St.

2

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

unnamed child

Dixon

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

single

6 DATE OF BIRTH

Aug 18

(Month)

(Day)

1914

(Year)

7 AGE

— yrs.

— mos.

3 ds.

If LESS than 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Maryland

PARENTS

10 NAME OF FATHER

George Dixon

11 BIRTHPLACE OF FATHER (State or country)

Pennsylvania

12 MAIDEN NAME OF MOTHER

Mary Long

13 BIRTHPLACE OF MOTHER (State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George Dixon

(Address)

Regentown Md

15

Filed

8/15

1914

Henry Davis

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug. 14

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Aug 11

1914

to

Aug 14

1914

that I last saw him alive on

Aug 14

1914

and that death occurred on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) yrs. mos. ds.

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed)

H. K. Newby, M. D.
8/15, 1914 (Address) Regentown Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Regentown Md

Aug 15

1914

20 UNDERTAKER

ADDRESS

H. K. Newby

Regentown

Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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RECEIVED
SEP 5 1914
BUREAU, U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

8247

County

Washington

Village or City

Darnville

(No.

St.;

Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

311

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

H. Douglas Downey

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Sept. 16, 1913
(Month) (Day) (Year)

7 AGE

10 yrs. 27 mos. 27 ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

Lewis Downey

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Maudie Shaw

13 BIRTHPLACE OF MOTHER (State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Maudie Downey

(Address)

Williamsport Md.

15

Filed

Aug 14 1914

W. M. Reichard

Local

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug. 13, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

Aug. 10, 1914, to Aug. 13, 1914,

that I last saw him alive on Aug. 13, 1914,

and that death occurred on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Spinal Meningitis

Contributory
Secondary

(Duration) yrs. mos. 3 ds.

(Signed)

W. D. Reichard, M. D.

Aug. 13, 1914 (Address) Williamsport Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Manor Cemetery

Aug 15, 1914

20 UNDERTAKER

ADDRESS

W. C. Reichard

Fairplay Ind.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

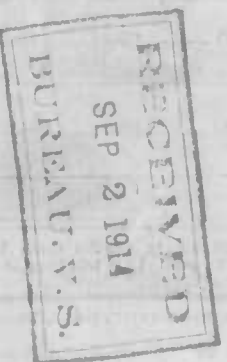
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Malaria* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestive," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Cræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 8248
County Washington

Village or City Williamsport (No. 104) Artisan St.; Ward—

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registered No. 301

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Ruth A Dyet

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Child

6 DATE OF BIRTH Apr 26, 1914
(Month) (Day) (Year)

7 AGE 3 yrs. 26 mos. 26 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work. Child
(b) General nature of industry, business, or establishment in which employed (or employer) Child

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER W. T. Dyet

11 BIRTHPLACE OF FATHER (State or country) West Virginia

12 MAIDEN NAME OF MOTHER Margaret Robert

13 BIRTHPLACE OF MOTHER (State or country) West Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. T. Dyet

(Address) Williamsport Md.

15 Filed Aug 23, 1914 C. E. Rickard
Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug. 21, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 18, 1914, to Aug 21, 1914, that I last saw her alive on Aug 21, 1914

and that death occurred on the date stated above, at 5 P. m.
The CAUSE OF DEATH* was as follows:

Inanition

(Duration) yrs. 2 mos. — ds.

Contributory (Secondary) Gastro-enteritis

(Duration) yrs. 3 mos. — ds.

(Signed) J. Walter Rayman, M. D.

Aug 23, 1914 (Address) Williamsport Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. to the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Williamsport Md

20 UNDERTAKER Lewis W. Kiehl

DATE OF BURIAL Aug 23, 1914

ADDRESS Williamsport Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

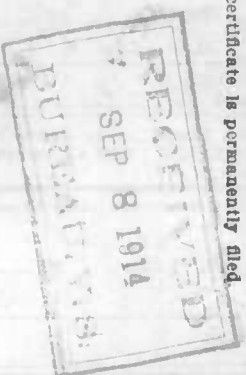
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer." "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not routinely employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indelible); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary, or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*, *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 8249
County Washington

Village or City Chesville (No. _____)

2 FULL NAME Mary Ann Foltz

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 306

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH 10 9 1824
(Month) (Day) (Year)

7 AGE 89 yrs. 10 mos. 28 ds. If LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Washington Co. Md.

10 NAME OF FATHER Jacob Stouffer

11 BIRTHPLACE OF FATHER (State or country) Washington Co.

12 MAIDEN NAME OF MOTHER Elizabeth Rimbey

13 BIRTHPLACE OF MOTHER (State or country) Washington Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant Ella M. Reynolds

(Address) Paynesboro. Pa.

15 Filed Aug 11 1914 J. H. Ferguson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 10, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May, 1914, to August 10, 1914,

that I last saw him alive on August 8, 1914

and that death occurred on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

Contributory (Secondary) As Thrombosis
(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Thos. I. Humphreys, M. D.
Aug. 11th, 1914. (Address) Chesville Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, it not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Chesville Md. DATE OF BURIAL Aug 11th, 1914

20 UNDERTAKER Geo. B. Hoover Smith ADDRESS _____

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

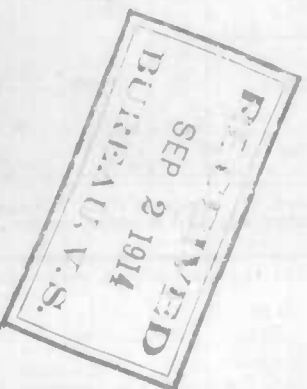
Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *pertinacium*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Tumiditas," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH <u>8250</u> <u>71</u> ✓		STATE OF MARYLAND	
County <u>Washington</u>		CERTIFICATE OF DEATH	
Village or City <u>Hagerstown</u> (No. <u>612</u> , <u>H. Mulberry</u> St.; <u>4</u> Ward)		Registration Dist. No. <u>302</u>	
2 FULL NAME <u>Robert W Foltz</u>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>	
6 DATE OF BIRTH <u>June 22</u> , 1914 (Month) (Day) (Year)			
7 AGE _____ yrs. <u>1</u> mos. <u>25</u> ds.		If LESS than 1 day, _____ hrs. OR _____ min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>none</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____			
9 BIRTHPLACE (State or country) <u>Md</u>			
PARENTS	10 NAME OF FATHER <u>Albert C. Foltz</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Md</u>		
	12 MAIDEN NAME OF MOTHER <u>Clara E. Funtz</u>		
	13 BIRTHPLACE OF MOTHER (State or country) <u>Md</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Albert C. Foltz</u> (Address) <u>Hagerstown Md</u>			
15 Filed <u>8-17</u> , 191 <u>4</u> <u>Henry Davis</u> REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>8</u> <u>16</u> , 191 <u>4</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____, that I last saw him <u>dying Aug 16</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>2:15 P.m.</u> The CAUSE OF DEATH* was as follows: <u>Convulsions</u> (Duration) _____ yrs. _____ mos. _____ ds. Contributory <u>Premature Birth</u> Secondary _____ (Duration) _____ yrs. _____ mos. _____ ds. (Signed) <u>H. M. Nissen</u> , M. D. <u>8-16</u> , 191 <u>4</u> (Address) <u>Hagerstown Md</u>			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. to the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____			
19 PLACE OF BURIAL OR REMOVAL <u>Beaver Creek Md</u>		DATE OF BURIAL <u>9/17</u> , 191 <u>4</u>	
20 UNDERTAKER <u>Watkins & Minnick</u>		ADDRESS <u>Hag. Md.</u>	

I If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

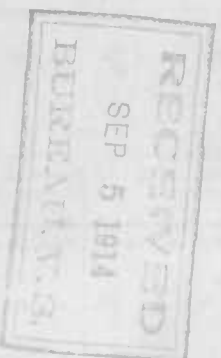
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death.—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculous* of *lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report more symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 8251

County Washington

Village or City Hagerstown (No. 705 Forest St. St.; 5 Ward)

2 FULL NAME

Unnamed child of Joseph & Feltz

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 302

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH 8 1 1914
(Month) (Day) (Year)

7 AGE Still Born If LESS than 1 day.....hrs. OR.....min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work none (b) General nature of industry, business, or establishment in which employed (or employer) ..

9 BIRTHPLACE (State or country) Md

PARENTS 10 NAME OF FATHER Joseph Feltz 11 BIRTHPLACE OF FATHER (State or country) Md 12 MAIDEN NAME OF MOTHER Madge Donblaser 13 BIRTHPLACE OF MOTHER (State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Joseph & Feltz (Address) Hagerstown Md

15 Filed 8/3- 1914 Henry Davis REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 8 1 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 8/1 1914 to 8/1 1914 that I last saw him alive on 8/1 1914

and that death occurred on the date stated above, at 3 30 P.M.
The CAUSE OF DEATH* was as follows:

Premature birth at 6 mos. gestation
(Duration)yrs.mos.ds.
Contributory Premature
Secondary
(Duration)yrs.mos.ds.

(Signed) W. E. Hoff M. D. 8/2 1914 (Address) Hagerstown

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Angels Hill Cemetery DATE OF BURIAL Aug 2 1914 20 UNDERTAKER Watkin Minnick ADDRESS Hagerstown Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con- genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Maras-mus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæ-mia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For vio-lent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—ac-ci-dent*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 8252

County WashVillage or City Clear Spring No. 120STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 303

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Joseph M. Garver

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widower

6 DATE OF BIRTH May 14, 1848
(Month) (Day) (Year)

7 AGE 66 yrs. 2 mos. 29 ds. OR 1 LESS than 1 day, 29 hrs. OR 29 min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Proprietor Hotel
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Ind

PARENTS
10 NAME OF FATHER Joseph Garver
11 BIRTHPLACE OF FATHER (State or country) Ind
12 MAIDEN NAME OF MOTHER Miss Staubs
13 BIRTHPLACE OF MOTHER (State or country) Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hattie Ankensby(Address) Clear Spring

15 Filed Aug 14, 1914 David S. Miller
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug. 13th, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from April, 1914 to Aug., 1914

that I last saw him alive on 11 AM, 1914

and that death occurred on the date stated above, at 11:30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(Duration) 5 yrs. 5 mos. 5 ds.

Contributory
Secondary

(Duration) 5 yrs. 5 mos. 5 ds.

(Signed) Chas. T. Mason, M. D.

Aug 13, 1914 (Address) Clear Spring Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Lutheran Cemetery Aug 15, 1914

20 UNDERTAKER ADDRESS

Chas. T. Mason Clear Spring

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

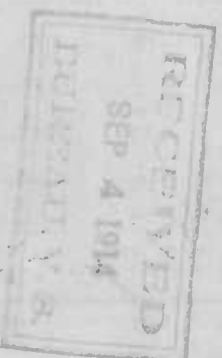
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) infection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-renal," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probable* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 8253
County Washington

Village or City Williamsport (No. Artisan)

2 FULL NAME Alfonza Gottone

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. B 01

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Italian 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Child
(Write the word)

6 DATE OF BIRTH July 7th, 1914
(Month) (Day) (Year)

7 AGE 1 yrs. 1 mos. 1 ds. OR 1 day, 1 hrs. 1 min. ?
If LESS than 1 day, hrs. min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer) Child

9 BIRTHPLACE (State or country) Maryland

PARENTS
10 NAME OF FATHER Louie Gottone
11 BIRTHPLACE OF FATHER (State or country) Italy
12 MAIDEN NAME OF MOTHER Costina Delingia
13 BIRTHPLACE OF MOTHER (State or country) Italy

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Louie Gottone
(Address) Williamsport Md

15 Filed Aug 14, 1914 E. Richard REGISTRAR
Local

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 13, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 13, 1914, to Aug 13, 1914, that I last saw him alive on Aug 13, 1914,

and that death occurred on the date stated above, at 12.30 P.m.

The CAUSE OF DEATH* was as follows:
Cholera Infantum

Contributory Exhaustion
Secondary

(Signed) Edw. Richardson, M. D.
Aug 13, 1914 (Address) Williamsport Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Williamsport Md DATE OF BURIAL Aug 14, 1914

20 UNDERTAKER Lucas W. Nepe ADDRESS Wm Sport

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

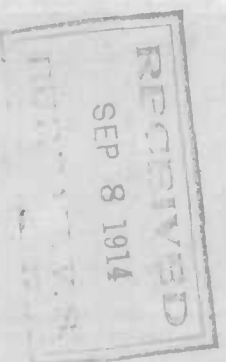
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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1 PLACE OF DEATH 8254

County

Washington

Village or City

Hagerstown (No. 111 Winter St.,

St.:

5th WardSTATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

302

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Unnamed child of Lewis Hasenbuehler

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

single

6 DATE OF BIRTH

August 20, 1914

7 AGE

1 day, 4 hrs. ?
If LESS than 1 day, 4 hrs. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

none

9 BIRTHPLACE

(State or country)

Washington Co. Md

PARENTS

10 NAME OF FATHER

Lewis Hasenbuehler

11 BIRTHPLACE OF FATHER (State or country)

W. Va.

12 MAIDEN NAME OF MOTHER

Mable W. Butler

13 BIRTHPLACE OF MOTHER (State or country)

W. Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lewis Hasenbuehler

(Address)

Hagerstown, Md.

15

Filed

8/21, 1914 Henry Davis

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

August 21, 1914

(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

Aug. 20, 1914, to Aug 20, 1914

that I last saw him alive on Aug 20, 1914

and that death occurred on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows:

Underdeveloped - Heart

(Duration) yrs. mos. ds.

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed)

H. E. Davis

M. D.

8/21, 1914 (Address) Hagerstown, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hagerstown, Md.

Aug. 21, 1914

20 UNDERTAKER

ADDRESS

H. E. Coffman

Hagerstown, Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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8255

Copied

1 PLACE OF DEATH
County Washington

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 302

Village or City Half-way (No. Near Hagerstown St. 2nd Ward)

2 FULL NAME Isaiah Halton

[If death occurred in a hospital or institution, give its NAME instead of street end number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Oct 8, 1836
(Month) (Day) (Year)

7 AGE 77 yrs. 10 mos. 14 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Government Service
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

PARENTS

10 NAME OF FATHER Daniel Halton

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Ann Smith

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Isaiah Halton Jr.
(Address) Half way

15 Filed 8/22, 1914 Henry Davis
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 22, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from August, 1914, to Aug 22, 1914, that I last saw him alive on Aug 20th, 1914, and that death occurred on the date stated above, at 59 m. The CAUSE OF DEATH* was as follows:
Exhaustion due to His Cholic

(Duration) _____ yrs. _____ mos. 3 ds.

Contributory
Secondary

(Signed) J. M. Scott, M. D.
Aug 22, 1914. (Address) Hagerstown

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, If not at place of death?
Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Hagerstown Md DATE OF BURIAL Aug 24, 1914

20 UNDERTAKER A. K. Coppersmith ADDRESS Hagerstown

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

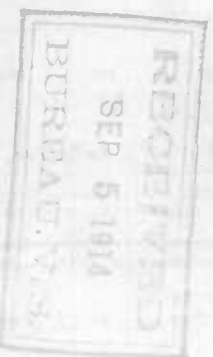
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH		8256		STATE OF MARYLAND	
County		Washington		CERTIFICATE OF DEATH	
Village or City		Hagerstown		Registration Dist. No. 302	
		(No. 11)		St. 5 th Ward	
2 FULL NAME		John F. Hill			
[If death occurred in a hospital or institution, give its NAME instead of street and number.]					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)			
male	colored	Widower			
6 DATE OF BIRTH					
June 11, 1951					
(Month) (Day) (Year)					
7 AGE					
63 yrs. 1 mos. 24 ds. If LESS than 1 day, hrs. OR min. ?					
8 OCCUPATION					
(a) Trade, profession, or particular kind of work. Laborer					
(b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country)					
Canada					
PARENTS	10 NAME OF FATHER				
	John Hill				
	11 BIRTHPLACE OF FATHER (State or country)				
	Canada				
12 MAIDEN NAME OF MOTHER					
Mariah Fennel					
13 BIRTHPLACE OF MOTHER (State or country)					
Canada					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE					
(Informant) Mrs. Anna Parish					
(Address) Hagerstown, Md.					
15					
8/4, 1914					
County Davis, REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH					
Aug 4, 1914					
(Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from some months, 1914, to His last day 4, 1914.					
that I last saw him alive on several days ago, 1914.					
and that death occurred on the date stated above, at 12:10 P.M.					
The CAUSE OF DEATH* was as follows:					
Cancer of the rectum					
(Duration) yrs. mos. ds.					
Contributory Secondary Cancer					
Some months (Duration) yrs. mos. ds.					
(Signed) Chas. B. Pizle, M. D.					
Aug 4, 1914 (Address) Hagerstown, Md.					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OF HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)					
At place of death yrs. mos. ds. In the State yrs. mos. ds.					
Where was disease contracted, If not at place of death?					
Former or usual residence					
19 PLACE OF BURIAL OR REMOVAL					
Hagerstown, Md.					
DATE OF BURIAL					
Aug 10, 1914					
20 UNDERTAKER					
A. R. Coffman					
ADDRESS					
Hagerstown, Md.					

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., or..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8257

(120) ✓

1 PLACE OF DEATH
County Washington

STATE OF MARYLAND
CERTIFICATE OF DEATH
Registration Dist. No. 362

Village or City Clearford Pike St.; — Ward)

[It death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Emma Kate Hoover

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female **4 COLOR OR RACE** White **5 SINGLE, MARRIED, WIDOWED, OR DIVORCED** Married
(Write the word)

6 DATE OF BIRTH Sept 1, 1865
(Month) (Day) (Year)

7 AGE 49 yrs. 6 mos. 8 ds. **11 LESS than** 1 day. — hrs. OR — min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer) —

9 BIRTHPLACE (State or country) Pa.

10 NAME OF FATHER Abraham Hart

11 BIRTHPLACE OF FATHER (State or country) Pa.

12 MAIDEN NAME OF MOTHER Mary E. Hartzell

13 BIRTHPLACE OF MOTHER (State or country) Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mr. Milton Hoover

(Address) Clearford Pike

15 Filed 8-11, 1914 Henry Davis
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 9, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Apr, 1914, to Aug 9, 1914.
that I last saw h. — alive on July 25, 1914.

and that death occurred on the date stated above, at 3 P m.
The CAUSE OF DEATH* was as follows:

Apoplexy
(Duration) — yrs. — mos. — ds.

Contributory Bright Disease
Secondary (Duration) 5 yrs. — mos. — ds.

(Signed) H. M. Nihiser, M. D.
Aug 10, 1914 (Address) Hagerstown, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death? —

Former or usual residence —

19 PLACE OF BURIAL OR REMOVAL Hagerstown, Md **DATE OF BURIAL** Aug 11, 1914.

20 UNDERTAKER A. K. Coppen **ADDRESS** Hagerstown

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

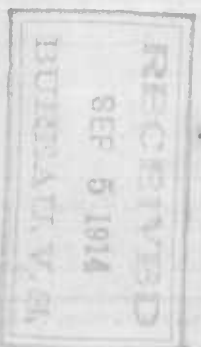
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thma," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PREPERAL septicæmia," "PREPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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PLACE OF DEATH 8258

County WashingtonVillage or City Hagerstown (No. 535, N. Mulberry St; 4 Ward)FULL NAME Laura J. HooverSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistered No. 302

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the words)

6 DATE OF BIRTH June 21, 1885
(Month) (Day) (Year)7 AGE 29 yrs. 1 mos. 20 ds. 11 LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Shirt Factory
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Hagerstown Md10 NAME OF FATHER Joseph H. Hoover11 BIRTHPLACE OF FATHER (State or country) Wash Co Md12 MAIDEN NAME OF MOTHER Laura E. Styrse13 BIRTHPLACE OF MOTHER (State or country) Wash Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph H. Hoover
535 N. Mulberry Hagerstown Md
(Address)

15 8/15, 1914 Henry Davis
Filed REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 11, 1914
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Aug 10, 1914 to Aug 11, 1914that I last saw him alive on Aug 11, 1914and that death occurred on the date stated above, at 1-10 P. m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion(Duration) 2 yrs. 2 mos. 2 ds.Contributory (Secondary) Prachia & Choleliths(Duration) 2 yrs. 2 mos. 2 ds.(Signed) Wm. Preston Miller, M.D.Aug 12, 1914 (Address) Hagerstown Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 2 yrs. 2 mos. 2 ds. In the State 2 yrs. 2 mos. 2 ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Rose Hill Hagerstown Md DATE OF BURIAL Aug 15, 191420 UNDERTAKER S. Keller Lowman Hagerstown Md ADDRESS _____

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state *WARS* or *INJURY* and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
SEP 5 1914
BUREAU, U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Washington</u>		8259		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Maugansville</u> (No. <u>42</u> ✓)		St.; <u>—</u> Ward		Registration Dist. No. <u>3/2</u>	
2 FULL NAME <u>Mrs. Lydia K. Horst.</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>married</u> (Write the word)			
6 DATE OF BIRTH <u>April 26</u> , 18 <u>43</u> (Month) (Day) (Year)		16 DATE OF DEATH <u>Aug 2</u> , 191 <u>4</u> (Month) (Day) (Year)			
7 AGE <u>71</u> yrs. <u>3</u> mos. <u>7</u> ds. OR <u>—</u> min. ?		17 I HEREBY CERTIFY, That I attended deceased from <u>Jan 4th</u> , 191 <u>4</u> , to <u>Aug 2nd</u> , 191 <u>4</u> . that I last saw him alive on <u>June 25th</u> , 191 <u>4</u> .			
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>"</u>		and that death occurred on the date stated above, at <u>11:15 A</u> m. The CAUSE OF DEATH* was as follows: <u>Uterine Cancer</u> <u>(Carcinoma)</u> (Duration) <u>2</u> yrs. <u>—</u> mos. <u>—</u> ds.			
9 BIRTHPLACE (State or country) <u>Penna</u>		Contributory <u>Neurophleg</u> , Secondary <u>resulting death</u> (Duration) <u>3</u> yrs. <u>—</u> mos. <u>—</u> ds.			
PARENTS	10 NAME OF FATHER <u>John Lisher</u>	(Signed) <u>Wm. H. Deane, M. D.</u> <u>Aug 2nd</u> , 191 <u>4</u> . (Address) <u>Neagusstown, Md.</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>Penna.</u>	*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
	12 MAIDEN NAME OF MOTHER <u>Nancy Krider</u>	18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. In the State <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. Where was disease contracted, It not at place of death? <u>—</u> Former or usual residence <u>—</u>			
	13 BIRTHPLACE OF MOTHER (State or country) <u>Penna.</u>	19 PLACE OF BURIAL OR REMOVAL <u>Riff's Mennonite Ch.</u> DATE OF BURIAL <u>8/5</u> , 191 <u>4</u> .			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Samuel Horst</u> (Address) <u>Maugansville, Md.</u>		20 UNDERTAKER <u>Em Shuter & Son Hagerstown, Md.</u>			
15 Filed <u>Aug 3^d</u> , 191 <u>4</u> <u>S. A. Hamish</u> REGISTRAR					

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

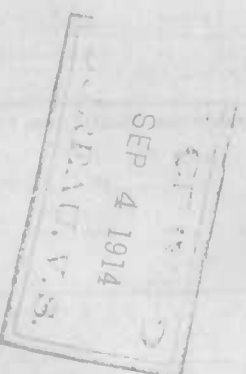
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tubercles of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 8260
 County Washington
 Village or City Hagerstown (No. Bethel St.; 5th Ward)
 2 FULL NAME Sadie Lillian Johnson

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Registration Dist. No. 302

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
 (Write the word)

6 DATE OF BIRTH Jan 25 - 1893
 (Month) (Day) (Year)

7 AGE 21 yrs. 6 mos. 2 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work Housekeeper
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

PARENTS
 10 NAME OF FATHER William D. Johnson
 11 BIRTHPLACE OF FATHER (State or country) Va
 12 MAIDEN NAME OF MOTHER Ida Burns
 13 BIRTHPLACE OF MOTHER (State or country) Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) William D. Johnson
 (Address) Hagerstown, Md

15 Filed 8/17, 1914 Herry Davis
 REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 302

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 16, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from July 1, 1914, to Aug 16, 1914,
 that I last saw her alive on Aug 16, 1914

and that death occurred on the date stated above, at 11:30 m.
 The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
 (Duration) 1 yrs. mos. ds.

Contributory
 Secondary
 (Duration) 2 yrs. mos. ds.

(Signed) J. R. Boudry, M. D.
Aug 17, 1914 (Address) Hagerstown, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
 At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
 If not at place of death?
 Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Hagerstown, Md DATE OF BURIAL Aug 18, 1914

20 UNDERTAKER A. K. Coppsman ADDRESS Hagerstown, Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

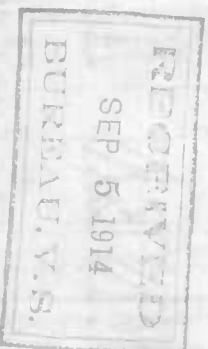
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Scutle," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* as such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 8261 101 ✓
 County Washington
 Village or City Hagerstown (No. Wash. County Sub. Hagerstown Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]
 2 FULL NAME Winnie Mae Jones

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH Oct 15 - 1886
 (Month) (Day) (Year)

7 AGE 27 yrs. 10 mos. 6 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work Housewife
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER H. Walters

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lophia Bloomer

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) John Jones
 (Address) Hagerstown, Md.

15 Filed 8-22 1914 W. Henry Davis
 REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 302

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 22nd, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 20, 1914, to Aug 21, 1914, that I last saw her alive on Aug 21, 1914.

and that death occurred on the date stated above, at 8:00 p.m.
 The CAUSE OF DEATH* was as follows:

Peritonitis
Unknown (Duration) yrs. mos. ds.

Contributory Intestinal obstruction
 Secondary (Duration) yrs. mos. ds. 3 ds.

(Signed) J. P. Laughlin, M. D.
Aug 22, 1914 (Address) Hagerstown Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
 At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?
 Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Hagerstown, Md. DATE OF BURIAL Aug 23, 1914

20 UNDERTAKER O. K. Coffman ADDRESS Hagerstown

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

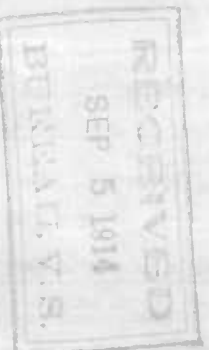
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report more symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUCHAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

8289

County WashingtonSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 302Village or City Hagerstown (No. Washington Co. Hospital; 3rd Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Pharinton King

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single
(Write the word)

6 DATE OF BIRTH Sept. 15, 1875
(Month) (Day) (Year)7 AGE 38 yrs. 11 mos. 5 ds. 5 It LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Day laborer
(b) General nature of industry, business, or establishment in which employed (or employer) ✓

9 BIRTHPLACE (State or country) Maryland10 NAME OF FATHER Hamilton King11 BIRTHPLACE OF FATHER (State or country) Maryland12 MAIDEN NAME OF MOTHER Annie Crampton13 BIRTHPLACE OF MOTHER (State or country) Heedysville

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Cornealus S. King(Address) W. 10 N. P. 100 ft. St. Hagerstown, Md.15 Filed 8/22, 1914 Henry Davis

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 20, 1914
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Aug 17, 1914, to Aug 20, 1914that I last saw him alive on Aug 19, 1914and that death occurred on the date stated above, at 8:28 a.m.

The CAUSE OF DEATH* was as follows:

Aphasia(Duration) yrs. 2 mos. 10 ds.Contributory Exhaustion

Secondary

(Signed) W. B. Brown, M. D.Aug 22, 1914 (Address) Hagerstown, Md.

*State the DISEASE CAUSING DEATH, of, in, deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. 1 mos. 15 ds. In the State yrs. mos. ds.

Where was disease contracted, It not at place of death?

Former or usual residence Hagerstown, Md.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Hagerstown, Md. Aug 22, 1914

20 UNDERTAKER ADDRESS

H. Coffman Hagerstown

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

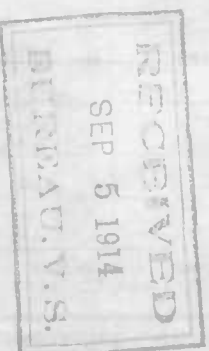
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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¹ PLACE OF DEATH 8262
County Washington

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 302

Village or City Hagerstown (No. 120, H Cannon Ave., 4 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

² FULL NAME Mrs. Nellie Lum

PERSONAL AND STATISTICAL PARTICULARS

³ SEX female ⁴ COLOR OR RACE white ⁵ SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

⁶ DATE OF BIRTH March 26, 1866
(Month) (Day) (Year)

⁷ AGE 48 yrs. 4 mos. 13 ds. If LESS than 1 day, hrs. OR min. ?

⁸ OCCUPATION
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer) _____

⁹ BIRTHPLACE (State or country) Md

PARENTS
¹⁰ NAME OF FATHER Cornelius M. Creager
¹¹ BIRTHPLACE OF FATHER (State or country) Md
¹² MAIDEN NAME OF MOTHER Jennie Becker
¹³ BIRTHPLACE OF MOTHER (State or country) Md

¹⁴ THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred Lum

(Address) Hagerstown Md

¹⁵ Filed 8/10, 1914 Henry Davis
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

¹⁶ DATE OF DEATH August 9th, 1914
(Month) (Day) (Year)

¹⁷ I HEREBY CERTIFY, That I attended deceased from August 3, 1914, to Aug 9th, 1914, that I last saw her alive on Aug - 9th, 1914

and that death occurred on the date stated above, at 12.30 am.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) yrs. mos. 2 / 1 ds.

Contributor Chronic Nephritis
Secondary

(Duration) yrs. mos. ds.

(Signed) H. P. Bender, M. D.
Aug 7, 1914 (Address) Hagerstown Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

¹⁸ LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

¹⁹ PLACE OF BURIAL OR REMOVAL Rose Will DATE OF BURIAL 9/11, 1914

²⁰ UNDERTAKER Watkins & Minnich ADDRESS Hag. Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

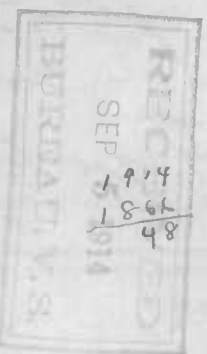
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH		8263		STATE OF MARYLAND	
County <u>Washington</u>		(V8)		CERTIFICATE OF DEATH	
Village or City <u>Hanover</u>		(No. _____) St.; _____ Ward		Registration Dist. No. <u>304</u>	
2 FULL NAME <u>Samuel D. McCallough</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]			
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)			
6 DATE OF BIRTH <u>Oct 15</u> , 1874 (Month) (Day) (Year)					
7 AGE <u>39</u> yrs. <u>10</u> mos. <u>14</u> ds. If LESS than 1 day, _____ hrs. OR _____ min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Laborer</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____					
9 BIRTHPLACE (State or country) <u>Pennsylvania</u>					
PARENTS	10 NAME OF FATHER <u>Samuel McCallough</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Pennsylvania</u>				
	12 MAIDEN NAME OF MOTHER <u>Francis Flora</u>				
	13 BIRTHPLACE OF MOTHER (State or country) <u>Lancaster Pa.</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Alice J. McCallough</u> (Address) <u>Hanover 2nd</u>					
15 FILED <u>Aug 30</u> , 1914 <u>JO. J. J. J.</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Aug 30</u> , 1914 (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>Aug 30</u> , 1914, to <u>same date</u> , 1914, that I last saw him alive on <u>Aug 30</u> , 1914, and that death occurred on the date stated above, at <u>10 a.m.</u> , The CAUSE OF DEATH* was as follows: <u>Pulmonary Tuberculosis</u> <u>acute</u> (Duration) <u>1</u> yrs. <u>1</u> mos. <u>1</u> ds. Contributory _____ Secondary _____ (Duration) _____ yrs. _____ mos. _____ ds. (Signed) <u>H. E. Tabb</u> , M. D. <u>Aug 31</u> , 1914 (Address) <u>Hanover Pa.</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Bethel Church Maryland</u> DATE OF BURIAL <u>Sept 1</u> , 1914					
20 UNDERTAKER <u>McCallough</u> ADDRESS <u>Hanover Pa.</u>					

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

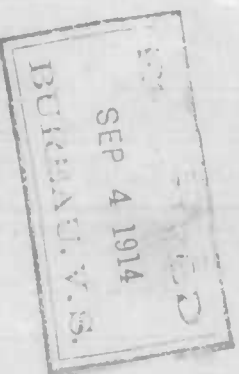
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the misadventure, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Irritation," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as "accidental," "suicidal," or "homicidal," or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 8264 40V
County Washington
Village or City Hagerstown (No. 42 1st Locust St; 4th Ward)
2 FULL NAME Emma N. Mansfield
Registered No. 302
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female
4 COLOR OR RACE White
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow
(Write the word)
6 DATE OF BIRTH May 13, 1863
(Month) (Day) (Year)
7 AGE 51 yrs. 3 mos. 10 ds. OR 1 day, 0 hrs. 0 min. ?
8 OCCUPATION
(a) Trade, profession, or particular kind of work Proprietor of
(b) General nature of industry, business, or establishment in which employed (or employer) Boardinghouse
9 BIRTHPLACE (State or country) Maryland

PARENTS

10 NAME OF FATHER John Hammond
11 BIRTHPLACE OF FATHER (State or country) Wash Co Md
12 MAIDEN NAME OF MOTHER Catherine Knodle
13 BIRTHPLACE OF MOTHER (State or country) Wash Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. D. Hammond
(Address) Hagerstown Md

15 8-25-, 1914 Henry Davis
Filed 8-25-, 1914 Henry Davis
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 23, 1914
(Month) (Day) (Year)
17 I HEREBY CERTIFY, That I attended deceased from April, 1914, to Aug 23, 1914,
that I last saw him alive on Aug 23, 1914,
and that death occurred on the date stated above, at 10:30 p.m.
The CAUSE OF DEATH* was as follows:
Canceroma

Contributory (Secondary)

(Duration) 6 yrs. 0 mos. 0 ds.
Exhaustion
(Duration) 5 yrs. 0 mos. 0 ds.
(Signed) Irvin M. Hertz, M. D.
Aug 23, 1914 (Address) Hagerstown

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.
Where was disease contracted,
If not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Bakersville, Lutheran DATE OF BURIAL Aug 26, 1914
20 UNDERTAKER Skella Loman Hagerstown Md. ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
SEP 5 1914
BUREAU, U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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¹ PLACE OF DEATH 8288
County WASHINGTON

Village or City HAGERSTOWN (No. WASH. CO. HOSPITAL St.; 3rd Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 302

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

² FULL NAME JOHN CLAUD MIDDLEKAUFF

PERSONAL AND STATISTICAL PARTICULARS

³ SEX MALE ⁴ COLOR OR RACE WHITE ⁵ SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write MARRIED.)

⁶ DATE OF BIRTH OCTOBER 9th, 1878.
(Month) (Day) (Year)

⁷ AGE 35 yrs. 10 mos. 8 ds. If LESS than 1 day, hrs. OR min. ?

⁸ OCCUPATION
(a) Trade, profession, or particular kind of work PATROLMAN
(b) General nature of industry, business, or establishment in which employed (or employer) HAG. POLICE FORCE.

⁹ BIRTHPLACE (State or country) MARYLAND.

PARENTS
¹⁰ NAME OF FATHER ROBERT MIDDLEKAUFF
¹¹ BIRTHPLACE OF FATHER (State or country) MARYLAND.
¹² MAIDEN NAME OF MOTHER CATHERINE JACQUES
¹³ BIRTHPLACE OF MOTHER (State or country) MARYLAND.

¹⁴ THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) ROBERT MIDDLEKAUFF

(Address) AVALON AVE.

¹⁵ Filed 8/19, 1914 Harry Davis
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

¹⁶ DATE OF DEATH Aug 16, 1914
(Month) (Day) (Year)

¹⁷ I HEREBY CERTIFY, That I attended deceased from Aug 15, 1914, to Aug 16, 1914, that I last saw him alive on Aug 16, 1914.

and that death occurred on the date stated above, at 10² m.
The CAUSE OF DEATH* was as follows:

Gun Shot wound of Abdomen
(Duration) yrs. mos. ds.

Contributory Secondary Shock

(Signed) W. Morrison, M. D.
Aug 18, 1914 (Address) Hagerstown Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OF HOMICIDAL.

¹⁸ LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

¹⁹ PLACE OF BURIAL OR REMOVAL ROSE HILL CEMETERY DATE OF BURIAL AUG. 19, 1914

²⁰ UNDERTAKER C. M. SUTER & SON ADDRESS HAGERSTOWN MD.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

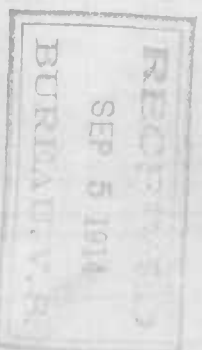
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Comatose," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train*; *Accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 8265
 County Washington
 Village or City Sharpsburg No. _____ St. _____ Ward) _____
2 FULL NAME Emma Alice Miller
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

Registration Dist. No. 300

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female **4 COLOR OR RACE** White **5 SINGLE, MARRIED, WIDOWED, OR DIVORCED** widowed
 (Write the word)

6 DATE OF BIRTH Jan. 7, 1860
 (Month) (Day) (Year)

7 AGE 54 yrs. 6 mos. 25 ds. It LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work Housewife
 (b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Daniel Mullendore

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Beachley

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Frederick Miller

(Address) Sharpsburg Md

15 Filed 8/3/, 1914 Chas. N. Hoffmaster

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 8 / 1 / 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from
7/31, 1914, to 8/1, 1914,

that I last saw her alive on 8/1, 1914

and that death occurred on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory Acute Indigestion
 Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) S. Howell Gardner, M. D.

8/3, 1914 (Address) Sharpsburg Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Sharpsburg Md **DATE OF BURIAL** Aug 4, 1914

20 UNDERTAKER Albert Lee Sharpsburg Md **ADDRESS** _____

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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1 PLACE OF DEATH 8266
County Washington

Village or City Clear Spring Dist. (No. 42)

2 FULL NAME Catherine C. Mills

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registered No. 303

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH unknown, 1 (Month) (Day) (Year)

7 AGE About 46 yrs. — mos. — ds. If LESS than 1 day, — hrs. OR — min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9 BIRTHPLACE (State or country)

Penn.

10 NAME OF FATHER

Joseph Britton

11 BIRTHPLACE OF FATHER (State or country)

Penn.

12 MAIDEN NAME OF MOTHER

Helena Daywalt

13 BIRTHPLACE OF MOTHER (State or country)

Penn.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Grant Mills

(Address)

Clear Spring Rd 3

15

Filed

Aug 8th, 1914 David S. Miller

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug. 7, 1914 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 191 to Mar. 15 1914.

that I last saw her alive on Mar. 15, 1914.

and that death occurred on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Uterine Cancer

(Duration) 2 yrs. — mos. — ds.

Contributory (Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) Henry C. Foster, M. D.

Aug. 7, 1914 (Address) Clear Spring

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death — yrs. — mos. — ds. in the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Blair Valley

Aug 9, 1914

20 UNDERTAKER

ADDRESS

Frank Bros Co

Clear Spring

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

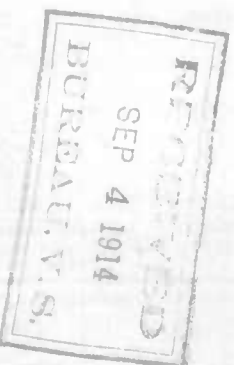
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 8267

County WashingtonVillage or City Near Fairfax (No. 119)Registration Dist. No. 311

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Kilian M. Munn

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Feb. 11, 1901
(Month) (Day) (Year)

7 AGE 14 yrs. 6 mos. 4 ds. It LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Charles Munn

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Isabel Wolf

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emma E. Wolf(Address) Wheaton St.

15 Filed Aug 16, 1914 V. M. Reichard
Lucas REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 15, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 10, 1914 to Aug 15, 1914.

that I last saw him alive on Aug 15, 1914.

and that death occurred on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

acute nephritis

(Duration) 2 yrs. 6 mos. 3 ds.

Contributory acute Rheumatic
Secondary Polyarthritis

(Signed) V. M. Reichard, M. D.

Aug 16, 1914 (Address) Fair Play

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Major Cemetery DATE OF BURIAL Aug 18, 1914

20 UNDERTAKER Dr. E. Reichard ADDRESS Fair Play

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

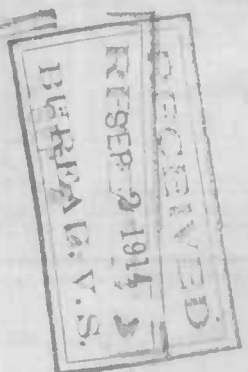
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If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

C. M. SUTER & SON HAGERSTOWN MD

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

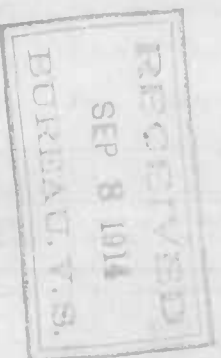
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1 PLACE OF DEATH Washington

County Washington

Village or City Lapland (No. 167)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registered No. 307

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Edwin Woodrow Reid

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single
(Write the word)

6 DATE OF BIRTH March 8, 1913
(Month) (Day) (Year)

7 AGE 1 yrs. 5 mos. 2 ds. It LESS than 1 day, 0 hrs. OR 0 min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer) none

9 BIRTHPLACE (State or country) Washington Co Md

10 NAME OF FATHER D. M. Reid

11 BIRTHPLACE OF FATHER (State or country) Washn Co Md

12 MAIDEN NAME OF MOTHER Grace Kartzel

13 BIRTHPLACE OF MOTHER (State or country) Washn Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo Kartzel

(Address) Lapland Md

15 Filed Aug, 1914

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 10, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 8, 1914, to Aug 10, 1914, that I last saw him alive on Aug 10, 1914

and that death occurred on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Scalding of face, arms
+ chest with boiling
water. accidental

(Duration) — yrs. — mos. 2 ds.

Contributory
(Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) A. L. Blessing, M. D.
1914 (Address) Lapland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Brownville Cemetery Aug 11, 1914

20 UNDERTAKER

ADDRESS

William F. Best Brownville Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

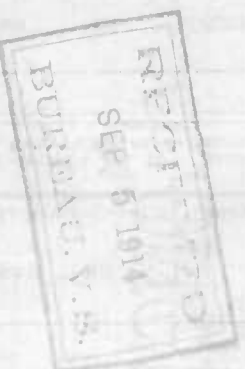
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PLACE OF DEATH **8270**
County **Washington**

Village or City **Smithsburg** (No. _____)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. **306**

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

FULL NAME **Henry C. Riddlemore**

PERSONAL AND STATISTICAL PARTICULARS

SEX **Male** COLOR OR RACE **White** SINGLE, MARRIED, WIDOWED, OR DIVORCED **Single**
(Write the word)

DATE OF BIRTH **11 29 1890**
(Month) (Day) (Year)

AGE **23 yrs. 8 mos. 8 ds.** If LESS than 1 day, _____ hrs. OR _____ min. ?

OCCUPATION
(a) Trade, profession, or particular kind of work **Druggist**
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (State or country) **Smithsburg**

NAME OF FATHER **H. Riddlemore**

BIRTHPLACE OF FATHER (State or country) **Smithsburg**

MAIDEN NAME OF MOTHER **Fannie Collouflood**

BIRTHPLACE OF MOTHER (State or country) **Smithsburg Md**

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant **Fannie Riddlemore**

(Address) **Smithsburg Md**

FILED **Aug 8 1914** **J. H. Ferguson**
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH **Aug 7 1914**
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from **Aug 6 1914** to **Aug 7 1914**, that I last saw him alive on **Aug 6 1914**

and that death occurred on the date stated above, at **5.9** m.

The CAUSE OF DEATH* was as follows:

Alcoholism

(Duration) yrs. **6** mos. ds.
Contributory (Secondary) **Acute Gastritis**

(Duration) yrs. mos. ds. **2**
(Signed) **M. K. Hoover**, M. D.
Aug 8 1914 (Address) **Smithsburg Md**

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. to the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL **Smithsburg Md** DATE OF BURIAL **Aug 9th 1914**

UNDERTAKER **Geo. B. Hoover** ADDRESS **Smithsburg**

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

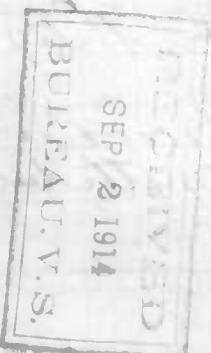
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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Washington</u>		8271	STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Brownsville Md</u> (No. <u>54</u>)		Registration Dist. No. <u>307</u>		[It death occurred in a hospital or institution, give its NAME instead of street and number.]
2 FULL NAME <u>Hallam B Ridman</u>		St.; Ward		
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)		
6 DATE OF BIRTH <u>9</u> <u>29</u> , 18 <u>96</u> (Month) (Day) (Year)				
7 AGE <u>18</u> yrs. <u>10</u> mos. <u>23</u> ds.		It LESS than 1 day, hrs. OR min. ?		
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>None</u>				
9 BIRTHPLACE (State or country) <u>Brownsville Md</u>				
PARENTS	10 NAME OF FATHER <u>Benjamin S Ridman</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>Hagerstown Md</u>			
	12 MAIDEN NAME OF MOTHER <u>Emma F Brown</u>			
	13 BIRTHPLACE OF MOTHER (State or country) <u>Brownsville Md</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Benjamin S Ridman</u> (Address) <u>Brownsville Md</u>				
15 Filed <u>Sept 2</u> , 191 <u>4</u> <u>C O Baker</u> REGISTRAR				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>8</u> <u>22</u> , 191 <u>4</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended deceased from <u>Sept</u> , 191 <u>4</u> , to <u>Aug 21</u> , 191 <u>4</u> , that I last saw her alive on <u>Aug 21</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>4</u> A. M. The CAUSE OF DEATH* was as follows: <u>Permeious Anemia</u> (Duration) yrs. <u>6</u> mos. — ds.				
Contributory Secondary (Duration) yrs. — mos. — ds.				
(Signed) <u>D. J. Youstis</u> , M. D. <u>8-22-14</u> (Address) <u>Brownsville</u>				
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.				
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. — mos. — ds. In the State yrs. — mos. — ds. Where was disease contracted, If not at place of death? Former or usual residence.				
19 PLACE OF BURIAL OR REMOVAL <u>Brownsville Md</u>			DATE OF BURIAL <u>8-24</u> , 191 <u>4</u>	
20 UNDERTAKER <u>C. L. Suman & Co</u>			ADDRESS <u>Kardysville Md</u>	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

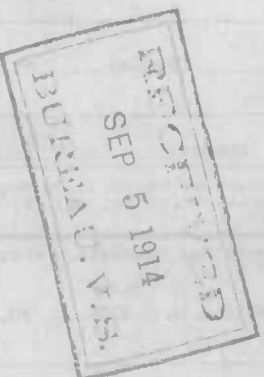
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH **8272**
County **Washington**

Village or City **Green Spring** No.

2 FULL NAME **Claude Roof**

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. **314**

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

St. Ward

PERSONAL AND STATISTICAL PARTICULARS

3 SEX **Male** 4 COLOR OR RACE **White** 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) **Single**

6 DATE OF BIRTH **Aug** (Month) **5** (Day) **1901** (Year)

7 AGE **13** yrs. **3** mos. **3** ds. It LESS than 1 day. hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

Adopted by the

9 BIRTHPLACE (State or country)

Cumberland Ind

10 NAME OF FATHER

Frank Otto

11 BIRTHPLACE OF FATHER (State or country)

Ind

12 MAIDEN NAME OF MOTHER

Bessie Wilson

13 BIRTHPLACE OF MOTHER (State or country)

Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant

James Grooms

(Address)

Big Spring Md.

15

Filed

Aug 10 1914

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH **Aug 8**, 1914 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____,

that I last saw him alive on _____, 191____,

and that death occurred on the date stated above, at **S.P.** m.

The CAUSE OF DEATH* was as follows:

Accident - Struck by lightning

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Signed) **David S. Miller, J. Pastor** (Duration) _____ yrs. _____ mos. _____ ds. **Aug 8**, 1914 (Address) **Clear Spring Md.**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, It not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Shankstown Ind **Aug 11**, 1914

20 UNDERTAKER

ADDRESS

Frank Boeser **Clear Spring Md**

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 22 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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<p>1 PLACE OF DEATH County <u>Washington</u></p>		<p>8273 (64)</p>		<p>STATE OF MARYLAND CERTIFICATE OF DEATH</p>	
<p>Village or City <u>Election District # 5</u></p>		<p>St.; _____ Ward)</p>		<p>Registration Dist. No. <u>304</u></p>	
<p>2 FULL NAME <u>John Wade Seavolt</u></p>					
<p>PERSONAL AND STATISTICAL PARTICULARS</p>					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)			
6 DATE OF BIRTH <u>February 7th, 1866</u> (Month) (Day) (Year)					
7 AGE <u>48</u> yrs. <u>6</u> mos. <u>3</u> ds. If LESS than 1 day, _____ hrs. OR _____ min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Machinist</u> (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>Washington Co Md</u>					
10 NAME OF FATHER <u>Daniel Seavolt</u>					
11 BIRTHPLACE OF FATHER (State or country) <u>Penna.</u>					
12 MAIDEN NAME OF MOTHER <u>Sally Wade</u>					
13 BIRTHPLACE OF MOTHER (State or country) <u>Md.</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Wright Seavolt</u> (Address) <u>Hancock Md.</u>					
15 Filed <u>Aug 11th, 1914</u> <u>J. P. Jenkins</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Aug 10, 1914</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from _____, 1914, to _____, 1914,					
that I last saw him alive on <u>Aug 8, 1914</u>					
and that death occurred on the date stated above, at <u>about 3 p.m.</u>					
The CAUSE OF DEATH* was as follows: <u>Cerebral Hemorrhage</u>					
(Duration) _____ yrs. _____ mos. _____ ds.					
Contributory Secondary (Duration) _____ yrs. _____ mos. _____ ds.					
(Signed) <u>H. E. Tabb</u> , M. D. <u>Aug 11, 1914</u> (Address) <u>Hancock Md</u>					
State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Milton Co Penna</u>				DATE OF BURIAL <u>Aug 12th, 1914</u>	
20 UNDERTAKER <u>M. Jenkins Son</u>				ADDRESS <u>Hancock Md.</u>	

If more blanks are needed, address State Registrar, E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

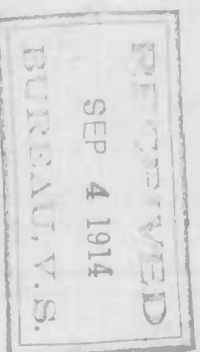
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

8274

9

County

Washington

Village or City

Near Smithsburg

(No.)

Registration Dist. No. 306

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Olive Pearl Shank

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

11 19 1903
(Month) (Day) (Year)

7 AGE

10 yrs. 8 mos. 29 ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Smithsburg Md

PARENTS

10 NAME OF FATHER

B. F. Shank

11 BIRTHPLACE OF FATHER (State or country)

Smithsburg Md

12 MAIDEN NAME OF MOTHER

Alice Smith

13 BIRTHPLACE OF MOTHER (State or country)

Near Smithsburg

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

B. F. Shank

(Address)

Smithsburg Md

15

Filed Aug 18th 1914

J. H. Ferguson

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug 18 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

Aug 9 1914, to Aug 18 1914,

that I last saw her alive on Aug 18 1914,

and that death occurred on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH* was as follows:

Leptemia

(Duration) yrs. mos. 16 ds.

Contributory (Secondary)

acute dilatation of heart

(Duration) yrs. mos. 1 ds.

(Signed)

G. A. H. Allen, Jr.

M. D.

Aug 18 1914 (Address) Smithsburg

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. to the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Smithsburg Md Aug 19th 1914

20 UNDERTAKER

ADDRESS

Geo. B. Hoover Smithsburg

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

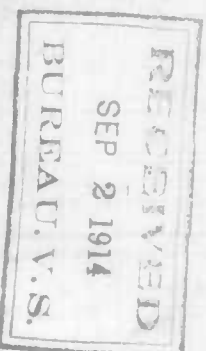
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *10 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tremor," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Washington</u>		8275	STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Hagerstown</u> (No. <u>118</u> , <u>Blooms Alley 5th</u> Ward)			Registration Dist. No. <u>302</u>	
2 FULL NAME <u>John Simpson</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>male</u>	4 COLOR OR RACE <u>colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>married</u> (Write the word)		
6 DATE OF BIRTH <u>Dec 10</u> , 18 <u>42</u> (Month) (Day) (Year)				
7 AGE <u>72</u> yrs. <u>9</u> mos. <u>28</u> ds.		If LESS than 1 day, _____ hrs. OR _____ min. ?		
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Soldier</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____				
9 BIRTHPLACE (State or country) <u>Virginia</u>				
PARENTS	10 NAME OF FATHER <u>Martin Simpson</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>Va</u>			
	12 MAIDEN NAME OF MOTHER <u>Fanny Smith</u>			
	13 BIRTHPLACE OF MOTHER (State or country) <u>Va</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs Fanny Smith</u> (Address) <u>Buffalo N. Y.</u>				
15 Filed <u>8-11-</u> , 191 <u>4</u> <u>Henry Davis</u> REGISTRAR				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>Aug 8</u> , 191 <u>4</u> (Month) (Day) (Year)				
I HEREBY CERTIFY, That I attended deceased from <u>July 23</u> , 191 <u>4</u> , to <u>Aug 8</u> , 191 <u>4</u> , that I last saw him alive on <u>Aug 8</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>3 p.</u> m. The CAUSE OF DEATH* was as follows: <u>Chronic Brights Disease</u>				
(Duration) <u>2</u> yrs. <u>0</u> mos. <u>0</u> ds.				
Contributory _____ Secondary _____				
(Signed) <u>Daniel C. Watkins</u> , M. D. <u>Aug 10</u> , 191 <u>4</u> (Address) <u>Hagerstown Md.</u>				
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.				
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____				
19 PLACE OF BURIAL OR REMOVAL <u>Hagerstown Md</u>		DATE OF BURIAL <u>Aug 11</u> , 191 <u>4</u>		
20 UNDERTAKER <u>A. K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>		

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

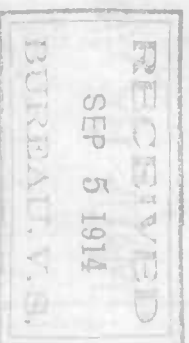
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercureant) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH **8276**
 County Washington
 Village or City Hagerstown (No. 224 Poplar St.; Ward)
 2 FULL NAME Mabelle Viola Smith
 Registered No. 302
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
 6 DATE OF BIRTH Nov. 30, 1913
 7 AGE 8 yrs. 9 mos. 9 ds. 1 LESS than 1 day, 0 hrs. 0 min.?
 8 OCCUPATION None
 (a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)
 9 BIRTHPLACE (State or country) Hagerstown Md

PARENTS

10 NAME OF FATHER Martin I Smith
 11 BIRTHPLACE OF FATHER (State or country) Wash. Co. Md
 12 MAIDEN NAME OF MOTHER Emma K. Baker
 13 BIRTHPLACE OF MOTHER (State or country) Wash. Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Martin I Smith

224 Poplar. Hagerstown Md

15 Filed 8/10, 1914 Henry Davis REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 9, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1914 to Aug 8, 1914, that I last saw him alive on Aug 8, 1914 and that death occurred on the date stated above, at 8:50 a.m.
 The CAUSE OF DEATH* was as follows:

Acute Catarrhal Enteritis
 (Duration) 14 yrs. 0 mos. 0 ds.

Contributory (Secondary)

(Signed) H. R. Bender, M. D.
Aug 10, 1914 (Address) Hagerstown, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.
 Where was disease contracted, If not at place of death?
 Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Rose Hill Hagerstown Md DATE OF BURIAL Aug 10, 1914

20 UNDERTAKER S. Kella Duman Hagerstown Md ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County

Washington

Village or City

Hancock

(No.

104

St;

Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registered No.

304

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Jesse Snyder

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Sept 3rd, 1913

(Month)

(Day)

(Year)

7 AGE

yrs. 11 mos. 19 ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Md

10 NAME OF FATHER

Dennis Snyder

PARENTS

11 BIRTHPLACE OF FATHER (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Lizzie Manning

13 BIRTHPLACE OF MOTHER (State or country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Dennis Snyder

(Address)

Hancock, Md. R.F.D.

15

Filed

Aug 27, 1914

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug. 22nd

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Aug 18th

1914

to

Aug 22nd

1914

that I last saw him alive on

Aug. 22nd

1914

and that death occurred on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Diarrhoea

(Duration)

yrs.

mos.

14 ds.

Contributory (Secondary)

Cholera Infantum

(Duration)

yrs.

mos.

4 ds.

(Signed)

J. H. Tobias

M. D.

8/22/1914

(Address)

Hancock, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

Dunstan Church Cem.

DATE OF BURIAL

Aug 23, 1914

20 UNDERTAKER

Albert Zimmerman

ADDRESS

Hancock 6 2nd

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

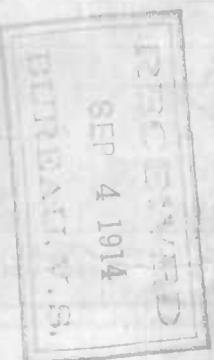
[Approved by U. S. Census and American Public Health Association.]

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1 PLACE OF DEATH 8278		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>WASHINGTON</u>		Registration Dist. No. <u>302</u>	
Village or City <u>HAGERSTOWN</u> (No. <u>701</u> , <u>WASHINGTON AVE</u> St., <u>1</u> Ward)		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
2 FULL NAME <u>MRS. CAROLINE SOCKS</u>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>FEMALE</u>	4 COLOR OR RACE <u>WHITE</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>WIDOW</u> (Write the word)	
6 DATE OF BIRTH <u>JULY</u> <u>9</u> th , <u>1835</u> (Month) (Day) (Year)			
7 AGE <u>79</u> yrs. <u>1</u> mos. <u>8</u> ds.		It LESS than 1 day.....hrs. OR.....min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>HOUSE-WIFE</u> (b) General nature of industry, business, or establishment in which employed (or employer) " " " " " " " " " " " "			
9 BIRTHPLACE (State or country) <u>GERMANY</u>			
PARENTS	10 NAME OF FATHER <u>ABRAHAM WELLINGER</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>GERMANY</u>		
	12 MAIDEN NAME OF MOTHER <u>CATHERINE KECK</u>		
13 BIRTHPLACE OF MOTHER (State or country) <u>GERMANY</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>MRS. JOHN NIGH</u> (Address) <u># 701 WASHINGTON AVE.</u>			
15 Filed <u>8/19</u> , 191 <u>4</u> <u>Harry Davis</u> REGISTRAR		MEDICAL CERTIFICATE OF DEATH	
		16 DATE OF DEATH <u>August 17</u> , 191 <u>4</u> (Month) (Day) (Year)	
		17 I HEREBY CERTIFY, That I attended deceased from <u>Jan 1</u> , 191 <u>4</u> , to <u>Aug 17</u> , 191 <u>4</u> , that I last saw h. <u>er</u> alive on <u>Aug 17</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>6 P</u> m. The CAUSE OF DEATH* was as follows: <u>Senility</u> (Duration) <u>6</u> yrs. <u>6</u> mos. <u>6</u> ds. Contributory <u>Exhaustion</u> Secondary (Duration) <u>1</u> yrs. <u>1</u> mos. <u>1</u> ds. (Signed) <u>M. B. Morrison</u> , M. D. <u>Aug 18</u> , 191 <u>4</u> (Address) <u>Hagerstown Md</u> *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.	
		18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u> </u> yrs. <u> </u> mos. <u> </u> ds. In the State <u> </u> yrs. <u> </u> mos. <u> </u> ds. Where was disease contracted, it not at place of death? Former or usual residence <u> </u>	
		19 PLACE OF BURIAL OR REMOVAL <u>ROSE HILL CEMETERY</u>	DATE OF BURIAL <u>AUG. 20</u> th , 191 <u>4</u>
		20 UNDERTAKER <u>C. M. SUTER & SON</u>	ADDRESS <u>HAGERSTOWN MD.</u>

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

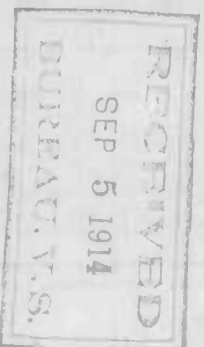
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 8279
 County Washington
 near Pr. Mar, Pa.
 Village or City (No. _____) St.; _____ Ward) 306
 2 FULL NAME Mary Gertrude Starliper

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single
 6 DATE OF BIRTH Sept. 3, 1876
 (Month) (Day) (Year)
 7 AGE 38 yrs. 11 mos. 5 ds. If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work none
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Chambersburg, Pa.
 10 NAME OF FATHER Wm. V. Starliper
 11 BIRTHPLACE OF FATHER (State or country) Franklin Co. Pa.
 12 MAIDEN NAME OF MOTHER Mary Reitzel
 13 BIRTHPLACE OF MOTHER (State or country) Franklin Co. Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. G. Sellers
 (Address) Chambersburg, Pa.

15 Filed Aug. 8, 1914 J. H. Ferguson
 REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug. 8, 1914
 (Month) (Day) (Year)
 17 I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1914 to Aug. 8, 1914,
 that I last saw her alive on Aug. 7, 1914,
 and that death occurred on the date stated above, at 6.30 a.m.
 The CAUSE OF DEATH* was as follows:

Acute Hypostatic Pneumonia

Contributory Cerebral Tumor
 Secondary (Duration) _____ yrs. _____ mos. 2 ds.

(Signed) S. B. Thomas, M. D.
Aug. 8, 1914 (Address) Waynesboro, Pa.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
 At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
 Where was disease contracted, If not at place of death?
 Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Chambersburg, Pa. DATE OF BURIAL Aug. 11, 1914

20 UNDERTAKER J. A. Sellers & Bros. Chambersburg Pa. ADDRESS _____

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

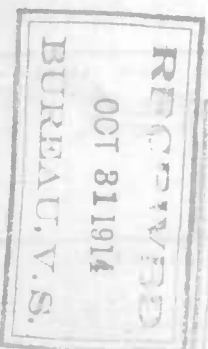
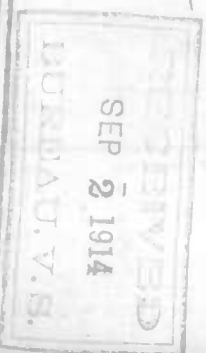
Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Maras- mus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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*sent out to
be signed
in this
form.*



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1 PLACE OF DEATH

County

Washington

8280

79

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

302

Village or City

Hagerstown (No. 303, W. Washington St.; 1st Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Robert St Clair

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

W.

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

unwed

6 DATE OF BIRTH

June 22, 1882
(Month) (Day) (Year)

7 AGE

75 yrs 1 mos 26 ds. OR LESS than 1 day, hrs. OR mo. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)

Penn

PARENTS

10 NAME OF FATHER

William St Clair

11 BIRTHPLACE OF FATHER
(State or country)

Scotland

12 MAIDEN NAME OF MOTHER

—

13 BIRTHPLACE OF MOTHER
(State or country)

—

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. C. C. Leyer

(Address)

802 W West St.

15

Filed

8/8-1914 Henry Davis

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug 8, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

1914 to Aug 7, 1914
that I last saw him alive on Aug 7, 1914

and that death occurred on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Chronic heart disease (unwed)

(Duration) 3 yrs. mos.

Contributory
(Secondary)

Pulmonary Emphysema

(Duration) 6 hours ds.

(Signed) Dr. Clinton Miller, M. D.

Aug 8, 1914 (Address) Marion & Dixon

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Grove Church Cem Aug 10, 1914

20 UNDERTAKER

ADDRESS

Harris Bros 33 E Wash St

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

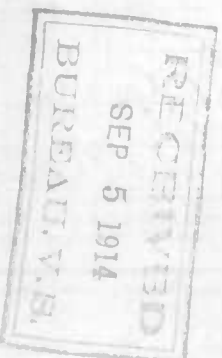
[Approved by U. S. Census and American Public Health
Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line, will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

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1 PLACE OF DEATH 8281
County Washington
Village or City Hancock (No. _____ St.; _____ Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 304

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME George Otis Tobias

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Oct. 20th, 1876.
(Month) (Day) (Year)

7 AGE 37 yrs. 10 mos. 9 ds. It LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work. Shoer
(b) General nature of industry, business, or establishment in which employed (or employer) Seal of Thomas Shoe Co., Charleston W. Va.

9 BIRTHPLACE (State or country) Ohio

10 NAME OF FATHER Isaac Tobias

11 BIRTHPLACE OF FATHER (State or country) Ohio

12 MAIDEN NAME OF MOTHER Nancy Ann Whitman

13 BIRTHPLACE OF MOTHER (State or country) Ohio

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. H. Tobias(Address) Hancock, Md.

15 Filed Aug 29, 1914 J. P. Jenkins
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 29, 1914.
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 28, 1914, to Aug 29, 1914.

that I last saw him alive on Aug 29, 1914

and that death occurred on the date stated above, at 8.30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary and
Laryngeal Tuberculosis
about (Duration) 1 yrs. _____ mos. _____ ds.

Contributory _____
Secondary _____

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) H. E. Tabler, M. D.
Aug 29, 1914 (Address) Hancock, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Peters Hill Cemetery, Ch. DATE OF BURIAL Aug 30, 1914

20 UNDERTAKER M. Jenkins Son ADDRESS Hancock Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

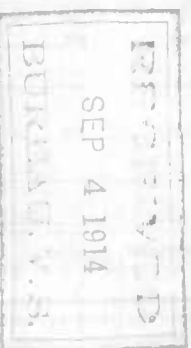
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1 PLACE OF DEATH

8282

County

Washington

Village or City

Mt. Zion

(No.)

St.

Ward)

Registration Dist. No. 306

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Thomas Burton Jones

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Widowed

6 DATE OF BIRTH

August 1

(Month)

(Day)

1839 (Year)

7 AGE

75

yrs.

mos.

3

ds.

It LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

Retired

9 BIRTHPLACE

(State or country)

Foxville Fordenichland

PARENTS

10 NAME OF FATHER

Abraham Jones

11 BIRTHPLACE OF FATHER

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER

(State or country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Dessie M. Stottlemyer

(Address)

Sandy Mt.

15

Filed Aug. 3rd 1914

J. H. Ferguson

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH

Aug 3

(Day)

1914 (Year)

17 I HEREBY CERTIFY, That I attended deceased from

July 30, 1914, to Aug 3, 1914.

that I last saw him alive on Aug 2, 1914.

and that death occurred on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Acute cerebrospinal meningitis

(Duration) yrs. mos. 5 ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) M. O. Refaiver, M. D.

Aug 3rd 1914 (Address) Smithsburg Md.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR REGENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mont Zion

Aug 4, 1914

20 UNDERTAKER

ADDRESS

Benjamin H. Hargis Smithsburg

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

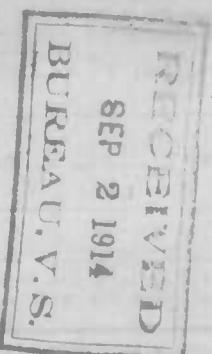
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Inspector*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubercular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very Important. See instructions on back of certificate.

1 PLACE OF DEATH 8283
 County Washington
 Village or City Farmington No. 19 St.; Ward)
 Registered No. 289
 [It death occurred in a hospital or institution, give its NAME instead of street and number.]
 2 FULL NAME Anna B. Trovell

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female
 4 COLOR OR RACE White
 5 MARRIAGE, Married
 (Write the word)
 6 DATE OF BIRTH Sept 14, 1851
 (Month) (Day) (Year)
 7 AGE 62 10 24
 yrs. mos. ds. It LESS than 1 day, hrs. min.?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work. House Wife
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Woodstock Shandoah Va.

10 NAME OF FATHER Samuel Hausenfloek
 11 BIRTHPLACE OF FATHER (State or country) don't know
 12 MAIDEN NAME OF MOTHER
 13 BIRTHPLACE OF MOTHER (State or country) Woodstock Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Trovell
 (Address) Farmington Md.

15 Filed Aug 10, 1914
Jessie Ramsey REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 8, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 7, 1914, to Aug 8, 1914,
 that I last saw her alive on Aug 8, 1914

and that death occurred on the date stated above, at 8 A. M.,
 The CAUSE OF DEATH* was as follows:

Acute indigestion and heart disease
 (Duration) yrs. mos. ds.
 Contributory (Secondary) Dilatation of
 (Duration) yrs. mos. ds.
 (Signed) W. S. Caffrey, M. D.
8/10, 1914 (Address) Farmington Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Farmington DATE OF BURIAL Aug 10, 1914

20 UNDERTAKER L. F. Beecher ADDRESS Farmington

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained from cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 8284

County

Washington

Village or City

Funkstown

(No.

St.; Ward)

Registration Dist. No.

309

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Miss Sophia Watz

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,

MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Single

6 DATE OF BIRTH

(Month) (Day) (Year)

7 AGE

80 about

If LESS than
1 day.....hrs.
yrs.....mos.....ds. OR.....min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

House Lady

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Funkstown Ind

10 NAME OF FATHER

Joseph Watz

11 BIRTHPLACE OF FATHER
(State or country)

Washington

12 MAIDEN NAME OF MOTHER

Susan Ault

13 BIRTHPLACE OF MOTHER
(State or country)

Washington

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs F. Smith

(Address)

Funkstown Ind

15

Filed

Aug 8, 1914 Jessie Ramsey

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug 6, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

Mar 1, 1914, to Aug 6, 1914.

that I last saw her alive on Aug 6, 1914.

and that death occurred on the date stated above, at 11:15 A.M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis
about
(Duration) yrs. mos. ds.Contributory
Secondary

Cardiac Exhaustion

(Duration) yrs. mos. ds.

(Signed)

A. P. Stuffer

M. D.

Aug 7, 1914 (Address) 18 Ferguson St.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Funkstown

Aug 8, 1914

20 UNDERTAKER

ADDRESS

L. F. Reccher

Funkstown

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 8285 ✓ (120)
 County Washington
 Village or City Hagerstown No. 121 E. North St.; 4 Ward
 Registration Dist. No. 302
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]
 2 FULL NAME David S. Wilson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widower
 (Write the word)

6 DATE OF BIRTH Feb 10, 1827
 (Month) (Day) (Year)

7 AGE 63 yrs. 5 mos. 24 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work Photographer
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Pa.

10 NAME OF FATHER James Wilson

11 BIRTHPLACE OF FATHER (State or country) Pa.

12 MAIDEN NAME OF MOTHER Ann. Worey

13 BIRTHPLACE OF MOTHER (State or country) Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F. J. Gabriel

(Address) Hagerstown, Md

15 Filed 8/4, 1914 Henny Davis
 REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 3, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY that I attended deceased from Aug 31, 1914, to Aug 31, 1914,
 that I last saw him alive on Aug 2, 1914.

and that death occurred on the date stated above, at 3 2 m.

The CAUSE OF DEATH* was as follows:

chronic Endocarditis
" Nephritis

(Duration) ? yrs. mos. ds.

Contributory
 Secondary

(Duration) yrs. mos. ds.

(Signed) J. E. Miller, M. D.

Aug 2, 1914. (Address) Mason-Dixon Rd.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Newcastle Pa Aug 5, 1914

20 UNDERTAKER ADDRESS

A. K. Coffman Hagerstown

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Washington</u>		8286		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Hagerstown</u>		No. <u>104</u>		Registration Dist. No. <u>302</u>	
2 FULL NAME <u>Lonia Welford</u>				[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>single</u> (Write the word)			
6 DATE OF BIRTH <u>Oct 13</u> , 19 <u>13</u> (Month) (Day) (Year)					
7 AGE <u>4</u> yrs. <u>10</u> mos. <u>17</u> ds. If LESS than 1 day, hrs. OR min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Infant</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>✓</u>					
9 BIRTHPLACE (State or country) <u>Maryland</u>					
PARENTS	10 NAME OF FATHER <u>W. W. Welford</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>W. Va</u>				
	12 MAIDEN NAME OF MOTHER <u>Mary E Carlisle</u>				
	13 BIRTHPLACE OF MOTHER (State or country) <u>W. Va</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>W. W. Welford</u> (Address) <u>Hagerstown, Md</u>					
15 Filed <u>8/30</u> , 19 <u>14</u> <u>Henry Davis</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Aug 30</u> , 19 <u>14</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, that I attended deceased from <u>Aug 29</u> , 19 <u>14</u> , to <u>Aug 30</u> , 19 <u>14</u> that I last saw him alive on <u>Aug 29</u> , 19 <u>14</u> and that death occurred on the date stated above, at <u>7:30 a.</u> m. The CAUSE OF DEATH* was as follows: <u>Cholera Infantum</u> (Duration) yrs. mos. <u>2</u> ds. Contributory <u>Acidosis</u> Secondary <u>Diarrhea</u> (Duration) yrs. mos. <u>6</u> mos. (Signed) <u>W. W. Welford</u> , M. D. <u>8/30</u> , 19 <u>14</u> (Address) <u>Hagerstown</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence.					
19 PLACE OF BURIAL OR REMOVAL <u>Romney W. Va</u> DATE OF BURIAL <u>Aug 31</u> , 19 <u>14</u>					
20 UNDERTAKER <u>A. L. Coffman</u> ADDRESS <u>Hagerstown, Md.</u>					

If more blanks are needed, address State Registrar, 6 E. Franklin St., E. B. Co., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

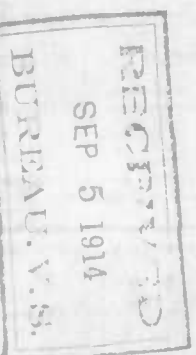
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—[Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic interstitial heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Washington</u>		8287	STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Hagerstown</u> (No. <u>315</u> <u>1</u> <u>Cannon Ave.</u> St. <u>3</u> Ward)		Registration Dist. No. <u>302</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]
2 FULL NAME <u>Edith Francis Woods</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>		
6 DATE OF BIRTH <u>Dec.</u> <u>17</u> , 19 <u>18</u> (Month) (Day) (Year)				
7 AGE <u>7</u> yrs. <u>23</u> mos. <u>23</u> ds.		If LESS than 1 day, ____ hrs. OR ____ min. ?		
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>none</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____				
9 BIRTHPLACE (State or country) <u>Md.</u>				
PARENTS	10 NAME OF FATHER <u>Chas L. Wood</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>Pa</u>			
	12 MAIDEN NAME OF MOTHER <u>Georgia Bomard</u>			
	13 BIRTHPLACE OF MOTHER (State or country) <u>Md</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Chas L. Wood</u> (Address) <u>Hagerstown Md</u>				
15 Filed <u>8/10</u> , 19 <u>18</u> at <u>Hagerstown</u> REGISTRAR				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>Aug 8</u> , 19 <u>18</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended deceased from <u>Aug 7th</u> , 19 <u>18</u> to <u>Aug 8th</u> , 19 <u>18</u> , that I last saw her alive on <u>Aug 8th</u> , 19 <u>18</u> , and that death occurred on the date stated above, at <u>11:30</u> a.m. The CAUSE OF DEATH* was as follows: <u>Cholera Infantum</u> (Duration) ____ yrs. ____ mos. <u>2</u> ds.				
Contributory Secondary (Signed) <u>A. P. Bender</u> , M. D. <u>Aug 8th</u> , 19 <u>18</u> (Address) <u>Hagerstown Md</u>				
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.				
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence. _____				
19 PLACE OF BURIAL OR REMOVAL <u>Rose Hill</u>			DATE OF BURIAL <u>8/10</u> , 19 <u>18</u>	
20 UNDERTAKER <u>Watkins & Minnick</u>			ADDRESS <u>Hoy, Md.</u>	

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